Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 09:30 on Wednesday 26 February 2025
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
09.30	1.	**Employee of the Month (February 2025)** *Purpose: To **note** the Employee of the Month presentations for February 2025*	Film	Chair *(10 mins)*
09.40	2.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	3.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	4.	**TB25/011 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 29 January 2025*	Report	
	5.	**TB25/012 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Performance Reports				
09.50	6.	**TB25/013 Integrated Performance Report** 6.1. Quality Indicators 6.2. Operational Indicators 6.3. Workforce Indicators 6.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report for assurance*	Report	L Barnes L Neary M Szpakowska G Lawrence *(30 mins)*
Committee Assurance Report				
10.20	7.	**TB25/014 Committee Assurance Reports** 7.1. Executive Committee	Report	R Cooper

		7.2. Audit Committee 7.3. Quality Committee 7.4. Strategic People Committee 7.5. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports for assurance*		S Connor G Brown L Knight C Spencer *(40 mins)*
Other Board Reports				
11.00	8.	**TB25/015 Maternity and Neonatal Services Assurance Report Quarter 3** *Purpose: To **note** the Maternity and Neonatal Services Assurance Report*	Report	L Barnes *(15 mins)*
11.15	9.	**TB25/016 2023/24 Safeguarding Annual Report (Adults and Children)** *Purpose: To **note** the 2023/24 Safeguarding Annual Report (Adults and Children)*	Report	L Barnes *(20 mins)*
Concluding Business				
11.35	10.	**Effectiveness of Meeting**	Report	Chair *(5 mins)*
11.40	11.	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*
		Date and time of next meeting: Wednesday 26 March 2025 at 09:30		**11.45 close**
15 minutes break				

Chair: Richard Fraser

The Board meeting is held in public and can be attended by members of the public to observe but is not a public meeting. Any questions for the Board may be submitted to Juanita.wallace@merseywestlancs.nhs.uk 48 hrs in advance of the meeting.

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 29 January 2025
(Approved at Trust Board on Wednesday 26 February 2025)

Name	Initials	Title
Gill Brown	GB	Non-Executive Director & Deputy Chair (Chair)
Rob Cooper	RC	Chief Executive
Anne-Marie Stretch	AMS	Deputy Chief Executive
Lynne Barnes	LB	Acting Director of Nursing, Midwifery & Governance
Nicola Bunce	NB	Director of Corporate Services
Steve Connor	SC	Non-Executive Director
Malcolm Gandy	MG	Director of Informatics
Gareth Lawrence	GL	Director of Finance and Information
Hazel Scott	HS	Non-Executive Director (via MS Teams)
Carole Spencer	CS	Non-Executive Director
Malise Szpakowska	MS	Acting Director of Human Resources
Rani Thind	RT	Associate Non-Executive Director (via MS Teams)
Peter Williams	PW	Medical Director

In Attendance

Name	Initials	Title
Angela Ball	AB	Halton Council Representative (Stakeholder Representative) (via MS Teams)
Marie Belcher	MB	Clinical Scientist / Respiratory & Sleep Service Manager (Observer) (via MS Teams)
Debbie Gould	DG	Quality and Safety Lead, Local Maternity and Neonatal System (Agenda Item 14) (via MS Teams)
Simon Halstead	SH	Buddy Healthcare (Observer) (via MS Teams)
Hannah Horsfield	HH	GE HealthCare (Observer) (via MS Teams)
Michelle Kitson,		Matron, Patient Experience (Agenda Item 2) (via MS Teams)
Catherine McClennan	CM	Senior Responsible Officer, Local Maternity and Neonatal System (Agenda Item 14) (via MS Teams)
Sophie Needham,	SN	Acute Oncology Specialist Nurse (Agenda Item 2) (via MS Teams)
Sue Orchard	SO	Divisional Director of Midwifery, Women's & Children's Division, (Agenda Item 14) (via MS Teams)
Kevin Thomas	KT	Divisional Medical Director, Women's and Children (Agenda Item 14) (via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Richard Fraser	RF	Chair
Lisa Knight	LK	Non-Executive Director
Lesley Neary	LN	Chief Operating Officer

Agenda Item	Description
The Chair made the following statement on behalf of the Trust Board: On behalf of the Trust Board, I would like to acknowledge the impact on the communities we serve, and many of our staff, of the Southport stabbings last summer and the recent trial at Liverpool Crown Court. Our thoughts will always be with those affected by that tragic day in July.	
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for December 2024 was Christine Pilkington, Occupational Therapist, Southport and Ormskirk Hospitals and the Board watched the film of LB reading the citation and presenting the award to Christine. 1.2. The Employee of the Month for January 2025 was Paul Murdock, Buyer Team Leader, Procurement and the Board watched the film of GL reading the citation and presenting the award to Paul. **RESOLVED:** The Board **noted** the Employees of the Month for December 2024 and January 2025 and congratulated the winners
2.	**Patient Story**
	2.1. GB welcomed MK and SN to the meeting. 2.2. MK introduced the Patient Story video in which a patient, who is a young mother of two children, shared her emotional journey following an unexpected diagnosis of cancer and the support that she received from SN, Acute Oncology Specialist Nurse. The patient described how she had been reassured by the urgency of arranging the investigations as well as having a point of contact. It had been important to the patient to continue breastfeeding her young baby and she had been supported to do this within the Accident and Emergency Department (A&E) and throughout her initial investigations with the support of the oncology team at Southport Hospital. 2.3. SN explained that one aspect of her role as an Acute Oncology Specialist Nurse was to support the patient and their families when they were diagnosed with a malignancy of unknown origin and to act as a key worker throughout the diagnostic journey by guiding the patient through the pathway of tests and results. 2.4. LB thanked MK and SN for sharing the patient's story. LB reflected on the difficulties of a patient attending multiple hospitals for treatment with two small children. SN responded that this patient had excellent family support, and her

	children regularly visited while she was an inpatient at Sheffield Teaching Hospitals NHS Foundation Trust. In other circumstances charities like Macmillan Cancer Support and Queenscourt Hospice have specialist child workers who support children diagnosed with cancer and the children of patients undergoing treatment. 2.5. SN advised that the patient was now in remission and had returned to work and was hoping to do some voluntary work for a Cancer Support Charity. 2.6. GB thanked SN for this update and commented that it was lovely to know that the patient's life had returned to normal. 2.7. HS reflected on a powerful patient story and asked if there had been an impact on the staff caring for her. SN acknowledged that the patient's story had resonated with her as she was also a mum of two young children. SN reflected on the strong support system within the oncology team. 2.8. GB commented that the Patient Stories were shared within the teams and asked what the reaction was to these. SN felt the learning from this story was the importance for the patient of being able to be seen and have investigations completed as an outpatient rather than being admitted. The brain pathway had allowed this to happen. This pathway for patients with a suspected brain tumour had been developed by the former STHK in 2022 and had been adopted at Southport in 2023. 2.9. RT asked if the acute oncology teams worked together, and SN confirmed that the team was fully integrated. 2.10. AMS commented that this was an excellent example of personalised care where the services had adapted to the individual needs of this patient. 2.11. GB reflected on how important clear communication and regular updates had been for the patient to reduce anxiety about the situation. 2.12. GB thanked MK and SN for the patient story and asked that they pass on the Board's thanks to the patient as well. *(MK and SN left the meeting)* **RESOLVED:** The Board **noted** the Patient Story
3.	**Chair's Welcome and Note of Apologies**
	3.1. GB welcomed all to the meeting including SH, HH and MB who were attending as observers. GB noted that SO and KT were attending to present Agenda Item 14 Clinical Negligence Scheme for Trusts 2024/25 Self Declaration along

	with CM and DG from the Local Maternity and Neonatal System (LMNS) who would be observing this item. 3.2. GB noted the apologies of RF, LK and LN. 3.3. It was noted that RC would be leaving the meeting at 12:30 to attend a meeting with NHSE. 3.4. GB acknowledged the following awards and recognition for Trust staff and services: 3.4.1. Katie Mann, Advanced Physiotherapist for Pelvic Health at Southport Hospital had been invited to the Houses of Parliament for the launch of a national report looking at gynaecology waiting lists. Katie was a contributor to the report by the Royal College of Obstetricians and Gynaecologists. 3.4.2. Natalie Heys was the first member of the St Helens District Nursing team to have completed the Registered Nurse Degree Apprenticeship (RNDA) course, gaining her registered nurse qualification. 3.4.3. The new National Institute for Health and Care Research (NIHR) Commercial Research Delivery Centre (CRDC) at NHS University Hospitals of Liverpool Group (UHLG) had been announced, and MWL has been selected as one of its ten research partners. 3.4.4. Whiston Hospital was the first hospital in the North of England to provide Aquablation Therapy surgery for benign prostatic hyperplasia (BPH) - non-cancerous, enlarged prostate - which affects up to three million men a year in the UK. 3.4.5. Onome Oyedokun, Sister, Southport Hospital won 'Preceptor of the Year' at the Nursing Times Workforce Awards 3.4.6. Professor May Ng, OBE, Consultant Paediatric Endocrinologist at Ormskirk Hospital has published her latest book called Autism Decoded 3.4.7. The Southport and Ormskirk sites Medical Education Awards winners were congratulated 3.5. GB advised that in December 2025 Sue Redfern (SR) had announced that she was stepping away from her role as Director of Nursing, Midwifery and Governance. SR would remain with the Trust and GB noted the Board's thanks to Sue and wished her well in her new role. 3.6. GB noted that this was RC's first Board meeting in his role as Chief Executive Officer (CEO) and wished him well. Apologies for absence were **noted** as detailed above
4.	**Declaration of Interests**
	4.1. There were no declarations of interests in relation to the agenda items.
5.	**TB25/001 Minutes of the previous meeting**

	5.1. The meeting reviewed the minutes of the meeting held on 27 November 2024 and approved them as a correct and accurate record of proceedings subject to the following amendments: 5.1.1. *8.3.1.3 to be amended to read '16 Patient Safety Incident Investigations (PSII) had been commissioned since October 2023 of which nine remained open'* 5.1.2. *15.1 to be amended to read 'the Intelligent Board'* **RESOLVED:** The Board **approved** the minutes from the meeting held on 27 November 2024 subject to the amendments detailed above
6.	**TB25/002 Matters Arising and Action Logs**
	6.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 6.2. The following action was closed: 6.2.1. Action Log number 1 (TB24/067 Statutory Pay Gap Report 2023/24) – The review of Electronic Staff Records (ESR) has shown that while the disability categories available are limited there is an opportunity to optimise the functionality available to improve our reporting. Action completed **RESOLVED:** The Board **approved** the action log.
Performance Reports	
7.	**TB25/003 Integrated Performance Report**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for December 2024 was presented.
7.1.	**Quality Indicators**
	7.1.1. LB and PW presented the Quality Indicators. 7.1.2. LB highlighted the following: 7.1.2.1. The inpatient Family and Friends Test (FTT) recommendation rate in December 2024 was 94.7% against a target of 90%. LB noted that the action plans agreed following the receipt of the National Inpatient Survey, the National Urgent and Emergency Care (UEC) Survey and the National Maternity Survey results, were being delivered. 7.1.2.2. The number of complaints responded to within 60 days in December was 62.5% against a target of 80%. LB advised that a MIAA audit of Complaints Management process had been undertaken, and substantial assurance was received. 7.1.2.3. The Nurse fill rate was 99% against a target of 90% despite the number of escalation beds.

	7.1.2.4. There had been nine cases of Clostridioides difficile (C.Diff) reported in December 2024 with 82 Year to Date (YTD) against a threshold of no more than 113 cases for 2024/25. 7.1.2.5. There had been 13 cases of Escherichia coli (E.Coli) reported in December 2024 with 124 YTD against a threshold of no more than 171 cases. 7.1.2.6. Infection, prevention and control (IPC) remained challenged with respiratory illnesses and many cases of diarrhoea and vomiting, mainly Norovirus , and there had been an increased focus on IPC as part of the quality and safety walkabouts 7.1.2.7. Falls (per 1,000 bed days) with harm remained an area of focus and there was a specific action plan in place to reduce the risk of falls in the higher incidence areas as well as ongoing falls education and regular audits of falls assessment compliance. 7.1.2.8. There had been no (zero) never events reported in December 2024. 7.1.3. PW highlighted the following: 7.1.3.1. The reported Hospital Standardised Mortality Ratio (HSMR) data was to March 2024 and no further updates had been received since the previous reported figures. PW noted that he had recently met with the Business Intelligence team to review the latest update from HSMR, and it was anticipated that more recent data would be available for the next Board meeting. 7.1.3.2. The latest Summary Hospital-level Mortality Indicator - Deaths associated with hospitalisation (SHMI) data was 1.03. 7.1.3.3. One neonatal death had been reported in December 2024 and related to a baby who was born at 36 + 4 with a known congenital anomaly and a plan for palliative care. The Perinatal Mortality Review Tool (PMRT) review was in progress. 7.1.4. PW reflected on the negative impact of the pressures leading to the critical incident on the quality and safety of care for patients.
7.2.	**Operational Indicators**
	7.2.1. GL, on behalf of LN, presented the operational indicators and highlighted the following: 7.2.1.1. The 4-hour mapped performance in December was 77% against a target of 78%. GL noted that whilst the Trust was in the top 20% of trusts nationally, ambulance handovers within 30 minutes had been challenged at 36.5% in December and this was mainly due to the long waits for admission in the ED as well as high number of Non-Criteria to Reside (NCTR) patients at 20.7% of beds. 7.2.1.2. GL noted that bed occupancy was at 97.8%, however, if the number of patients waiting to be admitted was included this would be circa 106%. There had been some improvement in January 2025, following the critical incident response.

	7.2.1.3. There had been an overall continued improvement in the referral to treatment (RTT) target to 59.9% of patients seen and treated within 18 weeks, in December 2024. 7.2.1.4. There had been remaining 83 65+week waiters at the end of December 2024 which were mainly due to complexity cases, patient choice as well as capacity issues, mainly in urology. A full review of the 52+ week waiters was being completed to gain an understanding of the trajectory to reduce these numbers. GL noted that the Trust had been the second-best performing Trust in Cheshire and Merseyside (C&M). 7.2.1.5. Performance against the 62-day cancer standard was 80.1%, national performance was 69.4% and C&M performance was 75.9% and GL noted that the Trust was in the top 20% nationally. 7.2.1.6. Performance against the 28-day cancer standard in November 2024 was 75%. 7.2.2. RC reflected on the high number of patients waiting in the ED and felt it was important to provide assurance to the Board of the actions being taken to maintain safe patient care, particularly with regards to pressure ulcers and falls. LB explained that the Trust had adopted the C&M red lines toolkit which included a nursing care indicator audits, and this provided assurance that patient safety processes in the ED was being maintained despite the high number of patients waiting for admission. Additionally, LB reflected that much of the feedback from the recent UEC patient survey had reflected patient frustration with long waiting times for admission to a bed and ambulance handover delays, so the actions required were to address these fundamental issues. LB also felt that the agreed early warning signs for escalation agreed with by the Trust and wider system as part of the recent critical incident would protect patients. For example, having an escalation threshold of 40 patients waiting for a bed in ED, would now trigger wider system actions to prevent escalation back into critical incident. 7.2.3. PW commented that to address delays in patients receiving a senior medical review when there were high numbers of patients awaiting admission, part of the escalation was now for Consultant Physicians to be redeployed to ED, and this meant that patients treatment continued and any patients suitable for discharge could be identified. 7.2.4. GL reflected on the need for cross organisational learning as the same issues were being faced by the ED at Southport. Additionally, GL commented that the Emergency Care Improvement Support Team (ECIST) was working with the Trust to help adopt best practice across the organisation. 7.2.5. RC reflected on the 83 65+week waiters and commented that, whilst the Trust had not achieved the target of zero 65+week waiters by the end of December 2024, it still compared well with peers and noted that the work that was been undertaken on theatre improvement would provide more

	capacity to reduce long waits. GL reported that the processes for planning theatre lists had been reviewed and standardised. 7.2.6. GB reflected on the challenges for staff to maintain patient experience during times of acute operational pressures and noted there had also been adverse weather conditions to contend with at the time. RC agreed that the staff response had demonstrated professionalism and true commitment. RC also noted that whilst Southport ED had not quite hit the triggers to declare a critical incident, it had also experienced severe pressure at the start of January. GB commented that it appeared most acute trusts in C&M were experiencing similar challenges. 7.2.7. AMS asked if C&M was more challenged than other areas of the country in terms of long waiters as the Trust position on 65+week waiters was benchmarked in the IPR as being in the worst 50% of all trusts. GL responded that in terms of absolute numbers there were many organisations with significantly higher numbers of long waiters. 7.2.8. RT asked how safety had been maintained for patients who were treated on the corridor in ED. LB commented that, whilst the Trust did not want to accept or normalise corridor care, there was a Standard Operating Procedure (SOP) in place which included strict criteria regarding how patients were managed in ED at the various stages of their journey through the department. During the critical incident staff from Southport Hospital ED had provided support for the team at Whiston, which had been greatly appreciated.
7.3.	**Workforce Indicators**
	7.3.1. MS presented the Workforce Indicators and highlighted the following: 7.3.1.1. The compliance rate for appraisals was 87.5% against the target of 85% and the Learning and Development Team were preparing for the launch of the next appraisal window on 01 April 2025. MS noted that feedback from the staff survey results would be used to help develop the appraisal process. A wellbeing discussion now formed part of the annual appraisal. 7.3.1.2. The compliance rate for mandatory training was above the target of 85% at 88% in December. The review of the MWL wide training needs analysis (TNA) was nearing completion and a proposal for standardised mandatory training requirements across MWL would be presented to the Executive Committee for implementation from April 2025. 7.3.1.3. Staff turnover was 0.7% in month against the target of 1.1% and had remained consistent since September 2024. 7.3.1.4. Sickness absence had increased to 6.7% in December 2024 against the 5% target, and this was 0.5% higher than the same period in 2023/24. Nursing staff sickness was 7% and Health Care Assistant (HCA) was 12%. The main reasons for sickness were cough, cold and flu, gastrointestinal illnesses, and stress, anxiety, and depression. Work remained ongoing to support staff back into the workplace.

	7.3.2. MS advised that there had been a low uptake nationally in the Covid-19 and flu vaccinations this year, however, despite being lower the Trust uptake compared favourably with other trusts in C&M. Currently 37.5% of Trust front line staff had been vaccinated for flu and 17% had taken up the offer of the Covid-19 vaccination. Across C&M the position was 38% uptake for flu and 20% uptake for Covid-19. GB asked if there was any intelligence on why staff were not having the vaccinations and MS responded that staff had a variety of reasons, but she had asked for these to be recorded so that they could be analysed. 7.3.3. RC asked if MS felt the Health Work and Wellbeing (HWWB) offer was as effective as it could be, given the increase in sickness absence. MS confirmed that as part of the integration work the HWWB offer was being reviewed and standardised across MWL. There was a HWWB dashboard with agreed performance metrics and these were generally performing as required, in terms of the traditional occupational health functions and the wider preventative support for staff, e.g. musculoskeletal health. Staff who engaged with wellbeing support and the Wellbeing Champions reported positive impacts from their engagement. RC queried why some staff might not take up the support offered by HWWB and MS responded that the main reasons for sickness absence was stress, anxiety and depression which often resulted from events outside of work, and staff may have support from their GP or other services in place. MS also noted that employee relations cases were stressful for all staff involved which was another reason for ensuring these cases were dealt with as quickly as possible. 7.3.4. SC reflected on the HCA sickness absence rate and asked why this was so high. MS advised that the rate was persistently high and had been 10% in the same period the previous year. A working group had been established to better understand the drivers for HCA sickness, but it was noted that this was a national issue and the HCA sickness at MWL was comparable with the levels at other trusts. LB commented that the current programme to address the band 2 – 3 roles may help increase the sense of value of this group of staff as it had been a long running issue. 7.3.5. NB asked if sickness absence was analysed by staff grade and whether there was a difference because HCAs could be a band 2, 3 or 4. MS agreed that this would be something for the working group to consider. Over the years several different approaches had been taken to HCA sickness, but none had yet made a lasting impact. 7.3.6. CS asked if the remit of the HWWB could be expanded to include an integrated family health offer, similar to some large business. MS responded that the fundamental purpose of the service was to ensure staff were fit to work and in healthcare it would always be important to focus on vaccinations and things like pre-employment checks as this was a patient safety issue. However, outside of this core business the Trust was

	continually reviewing how to deploy the available resource to achieve maximum impact on the health and wellbeing of staff.
7.4.	**Financial Indicators**
	7.4.1. GL presented the financial indicators and highlighted the following: 7.4.1.1. The final approved MWL financial plan for 2024/25 was a deficit of £10.9m which assumed: • Payment of £12m funds in line with the transaction business case • A Cost Improvement Programme (CIP) target of £48m (£36.2m recurrent and £11.8m non-recurrent) • Delivery of the 2024/25 elective activity plan • Non-recurrent deficit funding of £15.8m 7.4.1.2. At month 9 the Trust had reported a deficit of £10.7m which was £6.9m better than plan and it was noted that this was due to the £8m transaction support received in September and December 2024. Additionally, there was still an unmitigated industrial action pressure of £1.1m. 7.4.1.3. Agency spend was 3.7% of the pay bill against a target of 3.2% and work was ongoing to further improve this. 7.4.1.4. The Trust had delivered £39.9m CIP YTD, of which £32.8m was recurrent and a further £1.4m of recurrent CIP had been identified. 7.4.1.5. The Trust continued to forecast full delivery of the Capital Programme. 7.4.1.6. The cash balance at month 9 was £4.8m and it was expected that this would be circa £2m by the end of March 2025. 7.4.2. There were several risks to the forecast out turn and GL noted that in the last two weeks the Integrated Care Board (ICB) had received an offer from NHSE for elective performance which was based on what systems were planning to deliver, and this was currently being discussed. There had been an improvement in the RTT position and reduced waiting lists, however, the Trust's elective performance was behind plan and all resources were being utilised to reduce the impact on the underlying position. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
8.	**TB25/004 Committee Assurance Reports**
8.1.	**Executive Committee**
	8.1.1. RC presented the Executive Committee Assurance report from the meetings held in November and December 2024 and noted that any bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. Additionally, the meeting received Assurance Reports from the Premium Payments Scrutiny Council and the weekly vacancy control panel.

	8.1.2. RC highlighted the following: 8.1.2.1. There had been numerous discussions around the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme to review the evidence against each safety action and the final outcomes were being presented to Board later on the agenda. 8.1.2.2. The Executive Committee had received the regular reports on nurse safer staffing, risk management, mandatory training and appraisals, cyber security, financial improvement and Freedom of Information (FOI) performance. 8.1.2.3. The Committee had also received assurance on the implementation of the Theatre Utilisation Improvement Plan. 8.1.2.4. The Committee had reviewed the Digital Strategy first year assessment. 8.1.3. RC advised that the following investments had been approved during November and December 2024: 8.1.3.1. The Autonomous Working for Associate Specialist and Senior Associate Specialist (SAS) doctors. 8.1.3.2. There was continued focus on the Urgent and Emergency Care (UEC) Improvement Programme and winter plan with additional capacity approved to manage corridor care. 8.1.3.3. The transfer of the management of the St Helens Skill Academy to the Trust. 8.1.3.4. The alignment of Radiology waiting list initiatives (WLI) ates across the Trust to reduce reliance on agency and locum staff and to support increased productivity. 8.1.3.5. The Southport Emergency Department Nurse Staffing Business Case to increase the nurse establishment to meet demand and reduce reliance on bank and agency. 8.1.4. RT asked if the transfer of the St Helens Skills Academy would bring any additional workforce or financial risks. RC responded that this was an opportunity to provide a source of new recruits for NHS entry jobs, for example HCAs, who could develop their careers at the Trust and support local people into work. RC noted that the Council would transfer the grant funding to MWL, and this would cover the set up and revenue costs for a period of three years. After this there may be opportunities to attract further grant funding and generate income, to mitigate any future financial risk. MS advised that the model was to provide entry level opportunities for local people and there were several partners. NB commented that if the skills academy did not continue for any reason there would be alternatives uses for the building. The remainder of the report was **noted.**
8.2.	**Quality Committee**
	8.2.1. GB presented the Quality Committee Assurance Report for the meeting held on 21 January 2025 and highlighted the following:

	8.2.1.1. The Committee received the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) evidence and recommended that the report was presented to Board for final approval to make the self-declaration. The full report would be presented under Agenda Item 14 (TB25/010) with representatives from the Local Maternity and Neonatal System (LMNS) in attendance. 8.2.1.2. There had been one Never Event in November 2024 which related to wrong site surgery. 8.2.1.3. The Committee were concerned by the numbers of Methicillin-sensitive Staphylococcus Aureus bacteraemia (MSSA) reported as there had been 71 cases YTD compared to 39 in 2023/24 and referred this back to the Executive Committee to develop an action plan to improve IPC practice. <u>Urgent and Emergency Care (UEC) Patient Survey</u> 8.2.1.4. The Committee received the report and acknowledged that the focus needed to be on the wider UEC and patient flow improvements as these would have the greatest impact on patient experience. <u>Safeguarding Annual Report 2023/24</u> 8.2.1.5. The Committee received the report and commended the team for the alignment of Safeguarding policies and standardised procedures across MWL. 8.2.1.6. The MIAA audit of Safeguarding had provided substantial assurance, and all recommended actions had been completed. <u>Controlled Drug Responsible Officer Annual Report</u> 8.2.1.7. The Committee received the first MWL annual report by the Controlled Drug Accountable Officer which had provided a high level of assurance in relation to practice at the Trust. Benchmarking information was requested for future reports, if available. <u>Clinical Effectiveness Council Assurance Report</u> 8.2.1.8. The Committee received the Clinical Effectiveness Council Assurance reports for December and January and noted that the tele dermatology Artificial Intelligence (AI) project had launched in January 2025. This would increase the capacity of the service to meet increasing levels of demand, and the impact would be evaluated and reported in November 2025. 8.2.1.9. The amendments to the Death Certificate regulations and the resultant new process for the Medical Examiner had resulted in several delays issuing death certificates, but an escalation process had been put in place while the new national processes were embedding. <u>Care Quality Commission (CQC) Quarterly Update</u> 8.2.1.10. The Committee received the quarterly update and noted that the report of the unannounced inspection of the Whiston ED in March 2024 was due to be published. The report of the unannounced inspection at Southport ED had not yet been received for factual accuracy checking.

	8.2.1.11. 51 Ward Accreditation assessments had been completed with areas of good practice and key themes for learning shared. 8.2.1.12. 14 Quality Ward Rounds (QWR) had been completed in Q3, and these were now scheduled to follow the ward accreditation, so they could focus on the areas of improvement identified. 8.2.2. LB advised that the CQC team wanted to visit the Trust sites and were going to join a QWR each quarter. 8.2.3. AMS commented on the success of the ward accreditation scheme, and that the standardised metrics meant the wards understood which areas they needed to focus on to improve their star rating. LB agreed that the ward accreditation scheme was supporting improvements, and several wards originally rated as aspiring had now moved up the star rating scale. LB also noted that Ward 14a Orthopaedics, Southport Hospital had received a 5 star ward accreditation this month and was the second ward to achieve 5 stars. 8.2.4. MS asked if the accreditation scheme would be rolled out to other clinical areas. LB confirmed that the roll out plan was for the adult bed base first and once this had been completed the scheme would be evaluated. The next phase would be to add Women's and Children, then Theatres and Outpatients, followed by the EDs and community settings. LB noted that the adult bed base had been the initial priority in line with the 2024/25 Trust objectives. 8.2.5. CS reflected on the QWR she had recently attended for the Stroke unit and how proud the whole team were of the work they did. The remainder of the report was **noted**.
8.3.	**Strategic People Committee**
	8.3.1. CS, on behalf of LK, presented the Strategic People Committee (SPC) Assurance report for the meeting held on 22 January 2025 and highlighted the following: 8.3.1.1. The Committee reviewed the Workforce Committee Performance Report (CPR) and discussed the plans for improving appraisals in 2025/26. 8.3.1.2. The Committee had noted that the C&M ICB People Committee were also focusing on understanding HCA sickness rates, because it was an issue across all providers. 8.3.1.3. Average time to recruit had increased in December 2024 to 54.2 days against the target of 40 days, and remedial actions had been taken to improve performance. 8.3.1.4. The Committee received assurance reports covering: • Update on the Trust Objectives aligned to the SPC • Trust and Lead Employer Q3 People Plan progress reports. • The Equality, Diversity and Inclusion (EDI) Operational Plan Annual Update

	• The Organisational Development Operational Plan Annual Update 8.3.1.5. The Committee had noted the breadth of activity and suggested the identification of more success metrics, so progress could be quantified, which would also help to streamline reporting. 8.3.1.6. The Committee had noted the Statutory Pay Gap report and the improvement action plan. 8.3.1.7. The Committee received a briefing on the Trust's 2024 initial NHS Staff Survey results. A full report would be presented to Board with benchmarking once the full national results were published. 8.3.1.8. The Committee received council assurance reports from the People Performance Council, the HR Commercial Services Council and the Employee Relations Oversight Group 8.3.1.9. The Committee approved the updated Terms of Reference for the Valuing Our People Council. 8.3.2. RC reflected that the staff survey results would help the Trust to assess if all the actions reported to the SPC were being effective in improving the experience of staff, although he acknowledged that there was always a lag between the survey being undertaken and the results being published. MS agreed and commented that the Trust also promoted the national quarterly pulse surveys as a means of receiving more timely feedback, however the response rates were consistently low at the Trust and across the country. MS advised that the staff survey results would be used to create a heatmap across the organisation to allow for additional focus on areas which performed below the Trust average. However, it also remained important to triangulate with a range of other indicators of staff satisfaction. 8.3.3. AMS felt that the staff survey results could be analysed in many different ways and was a useful tool for the Executive to identify both hotspots and cross cutting themes, but it was also acknowledged that some of the changes took a long time to realise and not all issues could be addressed in a year. The remainder of the report was **noted**.
8.4.	**Finance and Performance Committee**
	8.4.1. CS presented the Finance and Performance Committee (F&P) Assurance report for the meeting held on 23 January 2025 and noted that this had been her first meeting as Chair of the Committee. It was noted that the Committee had reviewed the F&P CPR and monthly finance report, but the key points had already been discussed in earlier reports so would not be repeated. Other points to highlight from the report were: 8.4.1.1. The national planning guidance had not been received, and the Committee had received an update on the emerging information and the work being undertaken to plan for 2025/26 and the assumptions made so far. The difficulty of the current uncertainty was acknowledged. 8.4.1.2. The Committee had received the Month 9 CIP update and recognised the hard work in the delivery of a strong CIP programme with a pipeline for

	2025/26. There was also a presentation from Estates and Facilities providing assurance on the delivery against the service CIP target and the development of plans for 2025/26. 8.4.1.3. The Committee received the Urgent Care Programme Delivery Review which included an update on the recent critical incident. The Trust continued to engage with the ICB and PLACE partners to drive the improvements required to reduce pressures in the ED at Whiston Hospital and improve the discharge process and, whilst there were improvements seen during the critical incident, ongoing efforts were required to work with system partners to create a standard operating model for escalation when the trigger metrics were breached. 8.4.1.4. The Committee received the Service Line Reporting (SLR) and Patient Level Costing Information (PLIC) update, and it was noted that the Trust was 12 points under the SLR national cost collection index of 100 (overall 88, legacy STHK was 90 and legacy S&O was 104). GL had reminded the Committee that this was an internally calculated figure as the MWL data had been excluded from the national reporting because the dispute around the proposed treatment of the Public Finance Initiative (PFI) financial reporting changes. 8.4.2. The Committee received the council assurance reports from the Procurement Council, CIP Council, Capital Planning Council, Estates & Facilities Management Council, and IM&T Council. There had been no issues escalated to the Committee. 8.4.3. GB agreed that the input of the wider system was critical to effective managing of patient flows and avoiding future critical incidents. **RESOLVED:** The Board **noted** the Committee Assurance Reports
Other Board Reports	
9.	**TB25/005 Corporate Risk Register**
	9.1. NB presented the quarterly Corporate Risk Register (CRR) report which provided an overview of the risks that had been escalated to the MWL CRR via the Trust's risk management systems. NB advised that the risk management and reporting mechanisms continued to rely on the legacy trusts separate DATIX systems until the new MWL wide InPhase Risk and Incident Management System was implemented. 9.2. NB reported that the total number of risks on the MWL risk register at the end of December 2024 was 1,076 compared to 1,116 in October 2024. 17 risks were escalated to the CRR in December compared to 21 in October following the continued rationalisation and grouping of risks as well as the linking of duplicate risks from the two legacy risk management systems. NB noted that

all risks followed the approval process and were reviewed at divisional level and any risks escalated to the CRR were reviewed by an Executive lead.

9.3. NB highlighted the following:

9.3.1. There were a high number of unreviewed or overdue risks at the end of December 2024, but this was a seasonal pattern following the Christmas and new year holidays and many of the reviews had been completed ahead of the Risk Management Council meeting in January.

9.3.2. Appendix 1 provided more detail of the turnover of risks , the risk profiles for each legacy organisation, the CRR and details of the risks that had been closed or downgraded since the last quarterly report.

9.4. RT reflected on Risk 3574 (Patients in Careflow with an open referral and no future activity) and asked for more detail of this risk. MG responded that System C would be on site in the next few weeks, and this was one of the issues with the legacy STHK Careflow system that it was anticipated they would be able to resolve. RC clarified that the risk related to patients referred into the Trust who remained on an open pathway within the Careflow system, with no future actions noted. RC noted that this was a historical system error at the legacy STHK sites, and it was hoped that System C would now be able to correct this and allow the current workaround mitigations to be stood down. RT asked if this related to the previous 'lost to follow up' issue and RC clarified that it did not and also assured that patients were tracked and validated daily, to mitigate any risks. Although the issue had persisted for some time it was now hoped that the renewed focus of System C would finally create a solution. AMS asked for confirmation that there were workarounds in place to mitigate the risk to these patients and MG confirmed this was the case. Additionally, RC confirmed that patients were not closed or removed from the system.

9.5. SC reflected on the difference in the risk profile between the legacy organisations and asked if this indicated a lower risk appetite at the Southport and Ormskirk Hospital sites or if it reflected differences in the legacy risk management systems. NB responded that both were factors in this, but as the teams were coming together more consistency was emerging. NB also reflected that because of the known risks at the S&O sites with the fragile services and backlog maintenance there were some very specific risks for these sites, and these high and persistent risks may have impacted the different perceptions of risk. The unified divisional leadership structures and the new integrated risk management system would help to align the risk appetite across the Trust and between services.

9.6. MS commented that there had previously been a lot of awareness raising and education about the importance of reporting incidents and identifying risks at legacy STHK, and this was now needed across MWL with the introduction of the new InPhase system.

	RESOLVED: The Board **noted** the Corporate Risk Register
10.	**TB25/006 Board Assurance Framework**
	10.1. NB presented the quarterly review of the Board Assurance Framework (BAF) and noted that each BAF risk has been reviewed by the lead Executive and updates provided in relation to closed and new actions: 10.2. NB noted the following recommendations: 10.2.1. BAF 4 (Failure to protect the reputation of the Trust) to be amended to read '*Failure to maintain patient, partner and stakeholder confidence in the Trust*' as this changed the focus to reflect more accurately what was being managed. 10.2.2. The risk score for BAF 8 (Major and sustained failure of essential IT systems) to be increased to a score of 20 as there was currently no approved way forward for a single Electronic Patient Records (EPR) system, however, it was expected that by the next quarterly review the score would be decreased as a plan would then be in place. 10.3. RT reflected that BAF 8 did not include the implementation of the maternity information system for Whiston or the expansion of the Electronic Prescribing and Medicines Administration (EPMA) system at Southport as actions. MG agreed to review this for the next BAF update, but remained hopeful that by the next review firm plans would have been agreed to progress both these issues. **Action** MG to review BAF 8 to include the implementation of the maternity information system for Whiston or the expansion of the Electronic Prescribing and Medicines Administration (EPMA) system at Southport as actions 10.4. CS commented that the BAF was a detailed and helpful report and asked if the proposed actions were sufficient to achieve the target risk scores. For BAF 1 the current score was 20 and the target score 5, and CS asked if by taking on fragile services following the transaction the risk for some services were higher and if a heat map approach would be useful to target actions. NB responded that services were set up with systems and processes in place to manage the level of care needed and some areas would carry a higher level of risk than others, however, if there was evidence of guidance and processes not being followed it would highlight a systematic failure. NB commented that the controls put in place by the Board were designed to provide the systems and processes to avoid or mitigate the risk and the risk appetite in the BAF set the level of ambition for the Trust which was to never have a failure in the quality of care. CS asked if there was a tangible improvement trajectory. NB responded that the risk score had previously been lower and was increased to 20 whilst there were ongoing pressures in urgent and emergency care. PW commented that the BAF also reflected the external factors that the Board had to take account of and respond to, such

	as social care funding which had a direct impact on patient flow, which in turn led to a much poorer patient experience. 10.5. LB noted that BAF 1 included a new action to review the role of the Maternity and Neonatal Safety Champions and assured the meeting that, whilst there were no areas of concern, it was an opportunity to ensure the roles were adding maximum value. **RESOLVED:** The Board **approved** the increased risk score and changes to the Board Assurance Framework
11.	**TB25/007 2023/24 Research, Development and Innovation Annual Report**
	11.1. PW presented the 2023/24 Research, Development and Innovation (RD&I) Annual Report which provided an overview of the Research, Development and Innovation (RDI) activity in the Trust in 2023/24. PW noted that this was the first integrated RD&I report for MWL. 11.2. PW highlighted the following: 11.2.1. 4,348 participants had been recruited to research studies at MWL during the year. The Trust was the third largest recruiter on the Clinical Research Network, North West Coast (CRN NWC) dashboard. 11.2.2. There were 151 active research studies at Whiston and St Helens Hospitals and 58 at Southport and Ormskirk Hospitals. 11.2.3. The Trust had been ranked first, for the second year running on the CRN NWC dashboard for the number of responses to the Patient Research Experience Survey. 11.2.4. The Trust had secured funding from the National Institute of Health Research to expand dedicated research clinic space at both Whiston and Ormskirk Hospitals. 11.2.5. The Paediatric Diabetes team at Ormskirk Hospital was commended for randomising the first global patient to the RADIANT study. 11.2.6. The Mersey Regional Burn Centre won two research awards at the Journal of Wound Care Awards. 11.3. PW advised that the RD&I team also provided education and training, including “good practical clinical practise” training for staff. Additionally, the team supported career development opportunities through the National Institute for Health and Care Research (NIHR). There had been several research collaborations with local universities (Manchester Metropolitan University, Edge Hill University and Liverpool University) which included a collaboration for the Phase 1 Clinical Trials Centre at Liverpool University. 11.4. The report included an update on the financial management of the department including the funding allocations from NIHR. 11.5. PW noted that the RD&I department’s key objectives for 2024/25 included:

	11.5.1. Releasing a two-year interim Research Development and Innovation Strategy. 11.5.2. Continuing to increase the number of commercially sponsored studies. 11.5.3. Continuing to offer as many patients as possible the opportunity to take part in research. 11.5.4. Continuing to explore research options in specialities that were not already research active. 11.6. RT thanked PW for an excellent report and noted the gradual growth of research activity. RT asked how the team encouraged specialities that had not previously been research active to become involved, noting that research required time and the right opportunities. PW responded that the RD&I team provided excellent leadership and support in this area through engagement and collaboration with external organisations and to provide support to the departments and individuals. 11.7. AB also felt this was an excellent report and commented that she had been pleased to see that the impact factors on the publications had been included were available and asked PW to explain the significance of these. PW responded that the impact factor was a composite measure based upon how widely a journal was read and how much of an impact the published articles would have on clinical practice. 11.8. HS suggested that dedicated job plan time and support resources would encourage more clinicians to become involved in research. PW confirmed that the team did publicise the support available to anyone interested in becoming involved in research and this formed part of job planning discussions. 11.9. RT commented that at Advisory Appointment Committees (AAC) panels for the appointment of new consultants, candidates often expressed an interest in becoming involved in research and asked if this was fed back to Clinical Directors in the speciality areas. PW advised that he met with all newly appointed consultants six to eight weeks after taking up post and where they expressed an interest in research, he directed them to the RD&I team. PW recognised that in small specialities with only a few consultants it could be harder to carve out time for research in job plans. 11.10. GB asked PW to pass on the Board's thanks to the RD&I team for an excellent report. **RESOLVED:** The Board **noted** the 2023/24 Research, Development and Innovation Annual Report
12.	**TB25/008 Aggregated Incidents, Complaints and Claims Report (Q3)**

	12.1. LB presented the Aggregated Incidents, Complaints and Claims Report for quarter (Q)3 of 2024/25. 12.2. LB highlighted the following: 12.2.1. The new InPhase system would bring together all the incident, complaints and claims data from the legacy organisations to create fully integrated reporting based on standardised criteria. LB noted that historically the categorisation of incident types had been different, and this currently made direct comparisons difficult. 12.2.2. Any incidents resulting in harm were subject to an investigation to identify learning and improvement. 12.2.3. There had been 17 learning reviews, four expanded learning reviews and three Patient Safety Incident Investigations PSIIs) had been commissioned in Q3. 12.2.4. The Duty of Candour had been completed for reported patient safety incidents in Q3. 12.2.5. There had been an increase in complaints in Q3 and the response to first stage complaints within 60 days was 62.9% (57.44% in Q2) against a target of 80%. The main themes were clinical treatment and communication. LB noted that she and RC had recently received several compliments around end of life care, and this had been feedback to the teams involved. 12.2.6. The Patient Advise and Liaison Service (PALs) had received 1,156 enquiries in Q3. LB noted that the backlog in responses for the service at Whiston Hospital had now been resolved. 12.2.7. There had been a spike in the number of pre-action claims in Q3 of 2023/24, however, there had not been a corresponding increase in the number of new claims following this. There had been a low number of new claims received during Q3 of 2024/25, and LB noted that the Trust had been aware of most of these as these had been where there had either been a complaint or investigation. 12.2.8. The Trust had closed 41 inquests during Q3, and no prevention of future death notices had been received since July 2023. 12.3. RC reflected on the consistent theme of communication in complaints and PALs contacts and commented that the Patient Safety Incident Response Framework (PSIRF) had been designed to support the identification of themes and promote wider learning and asked if LB thought this was happening. LB responded that for MWL there had been an improvement in the sharing of learning across all sites, but it was still necessary to remind staff at Patient Safety Panels to continue to share learning more widely than their own ward or service. PW agreed with LB and commented that if the learning related to processes in a specific area or department the learning was not always applicable to other areas, however, to promote a learning culture it could still be important to do so. 12.4. RC asked how the Board could be assured that lessons were learnt and shared. LB explained that all investigation outcomes were documented on DATIX, and actions were managed by a panel who ensured that evidence of

	completion and sharing the learning was provided. LB noted that MIAA were undertaking an audit of the PSIRF process as part of the 2024/25 internal audit programme to test if it was effective. 12.5. AMS reflected on the spike in pre-action claims in 2023/24 and asked if there had been a reason for this. LB clarified that in October 2023 there had been changes to the national legal framework for claims which resulted in more patients asking for access to their medical records. GB noted that this had been discussed at the Quality Committee. 12.6. RT noted that there were 194 incidents related to labour and delivery at Ormskirk Maternity Unit and asked for more details on any trends or concerns. LB clarified that this was based on all incidents reported, and there was not a significant difference relative to the numbers of births between the Ormskirk and Whiston units, however this was an example of where the different legacy categorisation methodologies meant that the incidents at Whiston were categorised by different themes. LB confirmed that the new InPhase system would allow incidents to be analysed by themes or by service. GB suggested that for additional assurance the team analyse the Q3 data for Maternity services in more detail across MWL to ensure there were not any issues of concern. **Action** LB to review maternity incidents for Q3 **RESOLVED:** The Board **noted** the Aggregated Incidents, Complaints and Claims Report (Q3) *(RC left the meeting)*
13.	**TB25/009 Learning from Deaths Quarterly Report (Q1 2024/25**
	13.1. PW presented the Learning from Deaths Quarterly Report for Q1 of 2024/25 and noted that the two legacy organisations had adopted different approaches to the learning from deaths process, which were currently still in place. 13.2. PW highlighted the following: 13.2.1. There had been 76 deaths that met the criteria for a Structured Judgement Review (SJR) at legacy St Helens and Knowsley Teaching Hospitals NHS Trust (STHK), of which 48 had been completed. Of the cases reviewed, two were graded as amber and none were graded as red. 13.2.2. At legacy Southport and Ormskirk Hospital NHS Trust (S&O), 177 cases had undergone Medical Examiner Scrutiny and six SJRs had been completed. Of all the 177 cases reviewed six were graded as amber and one was graded as red. 13.3. PW reported that all cases graded as amber or red were further reviewed by the Mortality Groups with learning and additional actions being shared with

	the relevant divisions. PW noted that after a review cases were often downgraded as there was a greater understanding of the circumstances surrounding the deaths which were found to be unavoidable. 13.4. PW reported that two cases graded as amber following a SJR had been escalated to the Patient Safety Team for a full Patient Safety Incident Review (PSIR). 13.5. PW advised that the case graded as red, had been referred to the coroner. The case related to a patient, who following surgery for a fractured neck of femur had developed necrotising fasciitis and subsequently died. A documentary inquest had been concluded by the coroner and the cause of death was accident. PW noted that the IPC processes on the wards were being reviewed to ensure that there was nothing that could have been done differently. The case had subsequently been re-classified as amber. 13.6. PW noted that the key learning points for Q1 had been fed back through several forums including teaching and audit and the updates were available on the Trust's intranet. 13.7. AMS asked when the two legacy processes would be brought together into a single MWL approach to Learning from Deaths. PW responded that the medical management structure would have a single Assistant Medical Director with responsibility for the learning from death process, inquests and claims, and would have the responsibility for reviewing and harmonising these processes. PW noted that a single Mortality Review Group had now been established. 13.8. AMS reflected on the two cases graded as amber at legacy STHK that had been referred for a PSIR and asked why the other six cases graded as amber at legacy S&O had not been referred. PW responded that each case was reviewed to determine if it should be referred to the patient safety team who would determine if a PSIR or Patient Safety Review (PSR) were required. 13.9. AMS queried why the distribution PALs information was classed as learning. PW agreed that this was not a learning outcome and agreed to feedback to the team to ensure there was more consistency in reporting going forward. **RESOLVED:** The Board **noted** the Learning from Deaths Quarterly Report
14.	**TB25/010 Clinical Negligence Scheme for Trusts 2024/25 Self Declaration**
	14.1. GB welcomed KT, SO, CM and DG to the meeting. GB noted that RC had been called away to an urgent ICB meeting, however, he wanted the Board to be aware that he had reviewed the proposed declaration in detail with SO.

	14.2. LB introduced the Clinical Negligence Scheme for Trusts 2024/25 Self Declaration presentation which summarised the Trust's final position against each of the Maternity Incentive Scheme (MIS) year 6 safety actions to optimise the safety of women and babies. 14.3. LB noted that the report and supporting evidence had also been presented to the Executive Committee and Quality Committee. 14.4. SO and KT presented the detailed evidence of compliance against each of the ten CNST safety actions. 14.5. LB thanked SO and KT for the presentation and asked CM and DM whether they supported the submission of the Trust's self-declaration. CM responded that the evidence submitted had also been signed off and ratified at the LMNS Extraordinary Board meeting on 27 January 2025 on behalf of the ICB and final approval had only been subject to LMNS attendance at this meeting. CM assured that the LMNS agreed with the Trust's assessment of compliance against all ten safety actions and noted that once the Trust's CEO had signed the declaration this needed to be sent to the ICB to be counter signed before submission to NHS Resolution (NHSR). 14.6. CM acknowledged the intensive process and thanked the MWL team for their hard work. 14.7. GB also thanked the maternity teams for their hard work in delivering the MIS. **RESOLVED:** The Board **approved** the Clinical Negligence Scheme for Trusts 2024/25 Self Declaration *(SO, KT, CM and DG left the meeting)*
Concluding Business	
15.	**Effectiveness of Meeting**
	15.1. GB invited MB to reflect on the effectiveness of the meeting. MB commented that she attended the meeting as part of her Clinical Higher Specialist Scientific Training course and had found it useful to observe the flow of information to the Board and how this affected her service.
16.	**Any Other Business**
	16.1. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 13.22 The next Board meeting would be held on **Wednesday 26 February 2025 at 09.30**

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

Trust Board (Public)
Matters Arising Action Log
Action Log updated 21 February 2025

Mersey and West Lancashire Teaching Hospitals NHS Trust

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

Action Log Number	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion *(for overdue actions)*	Status
2	25/09/2024	**TB24/067 Statutory Pay Gap Report 2023/24**	Strategic People Committee asked to consider what the Trust value 'we are inclusive' means for staff	MS	~~01/01/2025~~ Apr-25		Report to be presented at Strategic People Committee
3	27/11/2024	**TB24/084 2024/25 Trust Objectives Mid-Year Review**	A report on actions being taken to improve discharges and reduce TTO delays to be presented at a future Quality Committee	LN & MG	Mar-25		Report to be presented at Quality Committee
4	29/01/2025	**TB25/006 Board Assurance Framework**	MG to review BAF 8 to include the implementation of the maternity information system for Whiston or the expansion of the Electronic Prescribing and Medicines Administration (EPMA) system at Southport as actions	MG	Apr-25		
5	29/01/2025	**TB25/008 Aggregated Incidents, Complaints and Claims Report (Q3)**	LB to review maternity incidents for Q3.	LB	May-25		

Completed Actions

Action Log Number	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
1	25/09/2024	**TB24/067 Statutory Pay Gap Report 2023/24**	MS to undertake a review of ESR to determine if different types of disabilities can be analysed.	MS	Jan-25	**29/01/2025** - The review of Electronic Staff Records (ESR) has shown that while the disability categories available are limited there is an opportunity to optimise the functionality available to improve our reporting. **Action completed**	**Completed**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	26 February 2026
Agenda Item	**TB25/013**			
Report Title	**Integrated Performance Report**			
Executive Lead	Gareth Lawrence, Director of Finance, and Information			
Presenting Officer	Gareth Lawrence, Director of Finance, and Information			
Action Required		**To Approve**	X	**To Note**

Purpose

The Integrated Performance Report provides an overview of performance for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) across four key areas:

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

Executive Summary

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

Financial Implications

The forecast for 2024/25 financial outturn will have implications for the finances of the Trust.

Quality and/or Equality Impact

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

Recommendations

The Trust Board is asked to note performance for assurance

Strategic Objectives

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

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Overview

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

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Jun-24	110.5	100	94.7	Best 40%
FFT - Inpatients % Recommended	Jan-25	94.0%	90.0%	94.6%	Best 50%
Nurse Fill Rates	Dec-24	96.4%	90.0%	96.7%	
C.difficile	Jan-25	12	113	94	
E.coli	Jan-25	12	171	136	
Hospital Acq Pressure Ulcers per 1000 bed days	Nov-24	0.08	0.00	0.13	
Falls ≥ moderate harm per 1000 bed days	Dec-24	0.11	0.00	0.19	
Stillbirths (intrapartum)	Jan-25	0	0	0	
Neonatal Deaths	Jan-25	0	0	9	
Never Events	Jan-25	1	0	3	
Complaints Responded In 60 Days	Jan-25	63.2%	80.0%	64.3%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Dec-24	78.2%	77.0%	73.6%	Worst 30%
Cancer 62 Days	Dec-24	75.7%	85.0%	78.5%	Best 20%
% Ambulance Handovers within 30 minutes	Jan-25	46.4%	95.0%	47.5%	
A&E Standard (Mapped)	Jan-25	78.6%	78.0%	77.8%	Best 20%
Average NEL LoS (excl Well Babies)	Jan-25	4.3	4.0	4.2	Best 30%
% of Patients With No Criteria to Reside	Jan-25	18.9%	10.0%	20.6%	
Discharges Before Noon	Jan-25	19.0%	20.0%	18.6%	
G&A Bed Occupancy	Jan-25	98.6%	92.0%	97.7%	Worst 30%
Patients Whose Operation Was Cancelled	Jan-25	0.9%	0.8%	0.9%	
RTT % less than 18 weeks	Jan-25	60.7%	92.0%	60.7%	Best 40%
RTT 65+	Jan-25	144	0	144	Worst 50%
% of E-discharge Summaries Sent Within 24 Hours	Jan-25	83.7%	90.0%	82.7%	
OP Letters to GP Within 7 Days	Dec-24	36.0%	90.0%	64.0%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jan-25	86.9%	85.0%	86.9%	
Mandatory Training	Jan-25	87.7%	85.0%	87.7%	
Sickness: All Staff Sickness Rate	Jan-25	7.1%	5.0%	6.0%	
Staffing: Turnover rate	Jan-25	0.6%	1.1%	0.9%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Jan-25		34,700	23,020	
Cash Balances - Days to Cover Operating Expenses	Jan-25	1.3	10		
Reported Surplus/Deficit (000's)	Jan-25		18,474	-13,126	

Board Summary - Quality

Quality

Friends and Family Test – achieved the overall target despite lower recommendation rates within Maternity Antenatal and Maternity Postnatal Ward. Performance impacted by low response rates which are addresses through use of QR codes, postcards and promotion of an online survey. Patient Experience and Inclusion Team to meet with maternity leads to review Maternity FFT action plan. The 2024 National Maternity Survey results have been received and a supporting action plan is in now in place.

Clostridium difficile infection – The Trust is on the NHSE threshold for 2024/25. In Q3 the MWL rate of 32.2 per 100,000 bed days is below the C&M rate of 38.6. MWL and the legacy Trusts have been below the C&M rate for the last four quarters. The CDI Improvement Plan remains on track.

E coli -The E coli Improvement Plan continues, and the Trust remains below the NHSE threshold.

Pressure Ulcers - Focused and generic actions have been developed in conjunction with wards and departments to address the themes. The TVN Team continue to provide teaching, awareness sessions and support to all areas, with a particular focus on ED, where quality improvement projects for pressure ulcer prevention are being embedded.

Patient Falls – The Falls Team have put together a specific action plan to reduce the risk of falls in higher incidence areas. There are regular audits of falls compliance and ongoing falls education. Falls reduction initiatives continue, including the expansion of the trial of de-caffeinated drinks and collaboration with Pharmacy and Frailty colleagues to increase medication reviews for patients at high risk of falling.

Never Events – A Never Events were reported in January (YTD 3). A Patient Safety Incident review has been undertaken which identified actions and lessons learned that have been communicated with staff. A PSII in the form of an MDT is underway and a Learning review is in progress.

HSMR - Data covers deaths in the Trust until June 2024. The latest month (Jun-24) HSMR for MWL was 110.5, primarily driven by increase in monthly HSMR at legacy STHK to 113.6, which although higher than expected is within tolerances for monthly variation. The was due to an in month increase in crude mortality at legacy STHK. All individual diagnoses groups with HSMR alert at STHK for this period have had deaths reviewed with none highlighting any areas of concern. The latest 12 months (ending Jun-24) had an overall low HSMR (93.0 for MWL, 95.9 for S&O and 91.9 for STHK). The YTD HSMR remains below 100 (94.7 for MWL, 90.7 S&O and 96.1 for STHK).

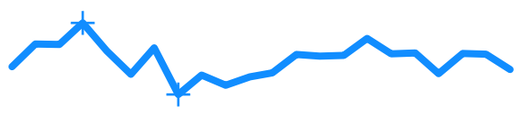
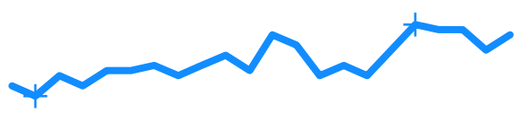
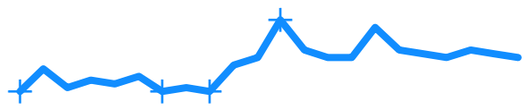
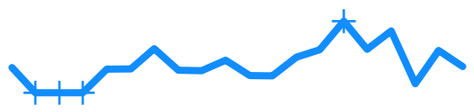
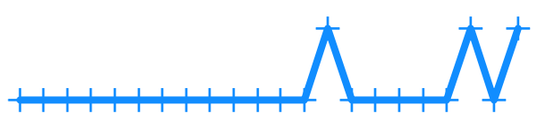
Complaints - % of stage 1 complaints resolved in 60 working days – performance remains consistent, but improvements noted in the average number of days from complaint receipt to closure and the number of complaints closed in month.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Jun-24	110.5	100	94.7	Best 30%	
FFT - Inpatients % Recommended	Jan-25	94.0%	90.0%	94.6%	Best 50%	
Nurse Fill Rates	Dec-24	96.4%	90.0%	96.7%		
C.difficile	Jan-25	12	113	94		
E.coli	Jan-25	12	171	136		
Hospital Acq Pressure Ulcers per 1000 bed days	Nov-24	0.08	0.00	0.13		
Falls ≥ moderate harm per 1000 bed days	Dec-24	0.11	0.00	0.19		
Stillbirths (intrapartum)	Jan-25	0	0	0		
Neonatal Deaths	Jan-25	0	0	9		
Never Events	Jan-25	1	0	3		
Complaints Responded In 60 Days	Jan-25	63.2%	80.0%	64.3%		

Board Summary - Operations

Operations

A&E - 4-hour performance increased in January, reporting 73.1% for all types against a target of 78%. Trust performance remained ahead of National (73.0%), and C&M (72.9%). The Trusts mapped 4-Hour performance achieved 78.6%.
The pressure across the A&E departments increased in January, particularly on the Whiston site, and a critical incident was declared on 06/01/25. The site remained in critical incident management and recovery, until 13/01/25, through this period performance and subsequent metrics improved and have been factored into current escalation management plans. Ambulance handover performance has also remained challenged but improved on the previous month.

Patient Flow - Bed occupancy across MWL continues to be significantly higher than the target of 92% and in January averaged 98.6%. The average length of stay for emergency admissions also remains high at 8.23 days. This is in part due to the high volume of patients with no criteria to reside, which in January was 18.9% across the sites. To manage demand and support improvements in handover performance, escalation beds across all sites remain open and options are being considered for further expansion of bed capacity across all sites. Work with local partners, including NWAS, is also ongoing and the C&M UEC Improvement Recovery Programme remains in place to support improvements in non-elective pathways from an in hospital and out of hospital perspective.

18 Weeks - 18-Week performance in January 2025 for MWL was 60.7%, an improvement of 0.8% on December. Improvements being seen on both legacy sites. Trust performance remains ahead of National (58.9% and C&M 56.7% - latest data Dec 24). At the end of January, the Trust reported 2,223 patients waiting over 52 weeks. Of this group, 144 patients were reported as waiting over 65 weeks, and 4 patients reported as waiting over 78 weeks. Of the 65 week breaches, 40% were due to patient choice, 18% a result of complex pathways, 39% due to a shortfall in capacity and the remaining patients corneal grafts. The 78-week breaches were due to patient choice and corneal grafts awaiting allocation of tissue.

Cancer - Performance against the Faster Diagnosis Standard (28-day) in December was increased to 78.2% against a target of 77%. Latest published data shows national performance of 78.1% and C&M regional performance of 75.5%. Performance for 62-day decreased to 75.7% (target 85%). The Trust remained ahead of C&M (74.9%) and National (71.3%). Improvement plans are in place across all tumour sites which set out trajectories and key actions being taken to achieve the Faster Diagnosis and 62-day standards for 2024/25. Deep dive reviews have also been undertaken in Skin, Urology and Colorectal to identify additional opportunities for improvement.

Diagnostics -Diagnostic performance in January achieved 93.6% for MWL, marginally behind the 95% target, with S&O achieving 94.7% and StHK 93.1%. MWL performance is ahead of national performance (latest month December) of 77.2% and C&M regional performance of 89.7%. An improvement trajectory is in place for all under-performing modalities. Additional scrutiny on the 13+ week waits has resulted in a reduction in the number of patients without a confirmed booking date.

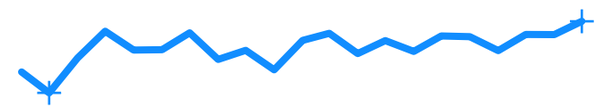
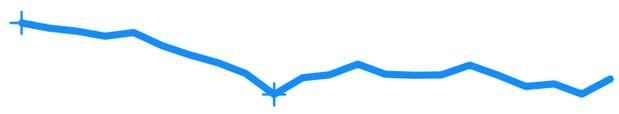
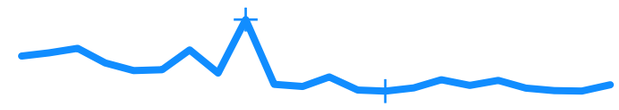
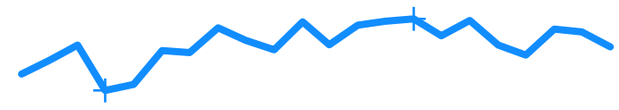
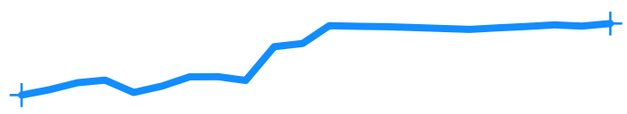
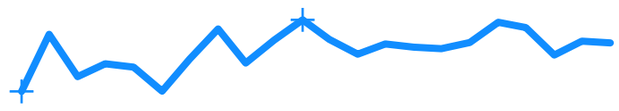
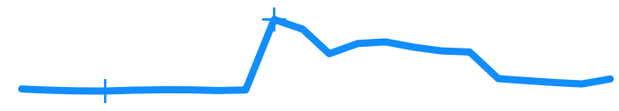
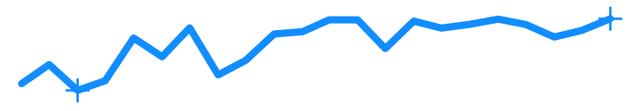
Letters - There has been a further decrease in performance, impacted by sickness, annual leave and vacancies within the department. The Trust is actively working on recruiting to our current vacancies and are ensuring that work is allocated accordingly to help support improvements on these targets moving forward. The teams are supporting with additional activity during evenings and weekends to help mitigate the issues where possible. Urgent letters are being produced within 48 hours of appointment.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Dec-24	78.2%	77.0%	73.6%	Worst 30%	
Cancer 62 Days	Dec-24	75.7%	85.0%	78.5%	Best 20%	
% Ambulance Handovers within 30 minutes	Jan-25	46.4%	95.0%	47.5%		
A&E Standard (Mapped)	Jan-25	78.6%	78.0%	77.8%	Best 20%	
Average NEL LoS (excl Well Babies)	Jan-25	4.3	4.0	4.2	Best 30%	
% of Patients With No Criteria to Reside	Jan-25	18.9%	10.0%	20.6%		
Discharges Before Noon	Jan-25	19.0%	20.0%	18.6%		
G&A Bed Occupancy	Jan-25	98.6%	92.0%	97.7%	Worst 30%	
Patients Whose Operation Was Cancelled	Jan-25	0.9%	0.8%	0.9%		
RTT % less than 18 weeks	Jan-25	60.7%	92.0%	60.7%	Best 50%	
RTT 65+	Jan-25	144	0	144	Worst 50%	
% of E-discharge Summaries Sent Within 24 Hours	Jan-25	83.7%	90.0%	82.7%		
OP Letters to GP Within 7 Days	Dec-24	36.0%	90.0%	64.0%		

Board Summary - Workforce

Workforce

Mandatory Training - The Trust continues to exceed its mandatory target at 87.7% against a target of 85%. Work continues to standardise our approach to the management and monitoring of core statutory and mandatory and compulsory skills training in line with the national framework.

Appraisals - The Trust is currently exceeding its appraisal target (85%) achieving 86.9%. The Learning and Development Team are preparing for the launch of the next appraisal window from 1st April 2025 and are supporting with appraisal and wellbeing conversation training.

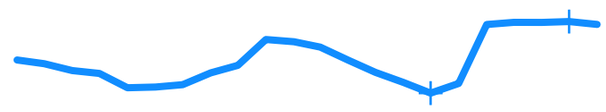
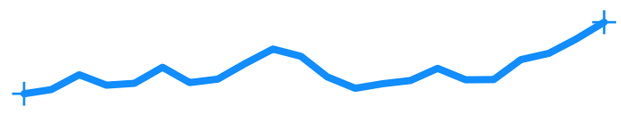
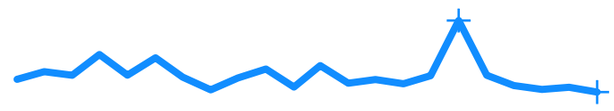
Sickness - In-month sickness remains above target, at 7.1% against the 5% target. This increase is reflective of the time of year and is a typical trend that we see each winter.
The top 3 reasons for sickness in January were 1) Stress, Anxiety & Depression, 2) Cough, Cold and Flu and 3) MSK. The Trust continues to focus on supporting all employees who are absent, and a review has been undertaken of the HR Absence support team to ensure we are providing staff and managers with timely support and guidance, to ensure that all supportive actions have been undertaken. This includes regular support sessions for managers and collaborative working with the Health Work and Wellbeing Team to ensure we are putting targeted support in place. The HR team are in the process of updating the Sickness and Absence policy and are working in collaboration with colleagues to further develop our wellbeing support including the tools and resources available to managers. This includes focusing on the embedding of meaningful wellbeing conversations and reasonable adjustments.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Jan-25	86.9%	85.0%	86.9%		
Mandatory Training	Jan-25	87.7%	85.0%	87.7%		
Sickness: All Staff Sickness Rate	Jan-25	7.1%	5.0%	6.0%		
Staffing: Turnover rate	Jan-25	0.6%	1.1%	0.9%		

Board Summary - Finance

Finance

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

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

Additional non-recurrent deficit support was agreed with commissioners during September. This has reduced the planned deficit by £15.8m, to a £10.9m deficit for 24/25. The Trust still awaits information on how the residual IA pressure will be dealt with within the system.

Surplus/Deficit – At Month 10, the Trust is reporting a year to date deficit of £13.1m which is £5.3m better than plan. This favourable variance relates to £8m of transaction support received in September and December, partly offset by pressures including £1m industrial action pressure and £1.6m pressure following the critical incident. The plan assumed all transaction support funding would be received in March 2025.

CIP - The Trust's CIP target for financial year 2024/25 is £48.0m, of which £36.2m is to be delivered recurrently and £11.8m non-recurrently. As at Month 10, the Trust has successfully transacted CIP of £41.6m, of which £33.7m is recurrent, with a further £1.0m of recurrent CIP at finalisation stage.

Cash - At the end of M10, the Trust's cash balance was £3.4m. The Trust anticipates a closing cash balance of c.£2.7m as per plan, at the end of the financial year.

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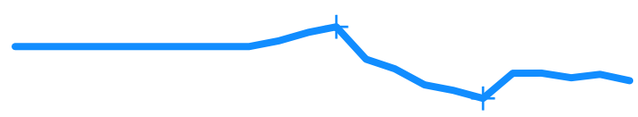
Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Jan-25		34,700	23,020		
Cash Balances - Days to Cover Operating Expenses	Jan-25	1.3	10			
Reported Surplus/Deficit (000's)	Jan-25		18,474	-13,1...		

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Legacy S&O

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Jun-24	101.2	100	90.7	
FFT - Inpatients % Recommended	Jan-25	94.1%	90.0%	94.2%	
Nurse Fill Rates	Dec-24	95.5%	90.0%	95.7%	
C.difficile	Jan-25	6		41	
E.coli	Jan-25	3		47	
Hospital Acq Pressure Ulcers per 1000 bed days	Nov-24	0.08	0.00	0.11	
Falls ≥ moderate harm per 1000 bed days	Dec-24	0.16	0.00	0.22	
Stillbirths (intrapartum)	Jan-25	0	0	0	
Neonatal Deaths	Jan-25	0	0	3	
Never Events	Jan-25	0	0	0	
Complaints Responded In 60 Days	Jan-25	63.6%	80.0%	67.5%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Dec-24	73.5%	77.0%	68.3%	
Cancer 62 Days	Dec-24	54.0%	85.0%	62.5%	
% Ambulance Handovers within 30 minutes	Jan-25	54.8%	95.0%	60.0%	
A&E Standard (Mapped)	Jan-25				
Average NEL LoS (excl Well Babies)	Jan-25	4.4	4.0	5.1	
% of Patients With No Criteria to Reside	Jan-25	16.4%	10.0%	16.7%	
Discharges Before Noon	Jan-25	17.4%	20.0%	19.3%	
G&A Bed Occupancy	Jan-25	98.0%	92.0%	97.0%	
Patients Whose Operation Was Cancelled	Jan-25	1.1%	0.8%	0.9%	
RTT % less than 18 weeks	Jan-25	64.3%	92.0%	64.3%	
RTT 65+	Jan-25	42	0	42	
% of E-discharge Summaries Sent Within 24 Hours	Jan-25	84.8%	90.0%	79.8%	
OP Letters to GP Within 7 Days	Dec-24	41.8%	90.0%	66.9%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jan-25	85.1%	85.0%	85.1%	
Mandatory Training	Jan-25	88.9%	85.0%	88.9%	
Sickness: All Staff Sickness Rate	Jan-25	6.8%	5.0%	6.2%	
Staffing: Turnover rate	Jan-25	0.6%	1.1%	0.8%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Jan-25				
Reported Surplus/Deficit (000's)	Jan-25				

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Legacy STHK

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Jun-24	113.6	100	96.1	
FFT - Inpatients % Recommended	Jan-25	93.9%	94.0%	94.8%	
Nurse Fill Rates	Dec-24	97.2%	90.0%	97.8%	
C.difficile	Jan-25	6		53	
E.coli	Jan-25	9		89	
Hospital Acq Pressure Ulcers per 1000 bed days	Nov-24	0.08	0.00	0.14	
Falls ≥ moderate harm per 1000 bed days	Dec-24	0.08	0.00	0.17	
Stillbirths (intrapartum)	Jan-25	0	0	0	
Neonatal Deaths	Jan-25	0	0	6	
Never Events	Jan-25	1	0	3	
Complaints Responded In 60 Days	Jan-25	62.5%	80.0%	62.3%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Dec-24	81.0%	77.0%	77.0%	
Cancer 62 Days	Dec-24	84.4%	85.0%	85.2%	
% Ambulance Handovers within 30 minutes	Jan-25	41.8%	95.0%	40.6%	
A&E Standard (Mapped)	Jan-25				
Average NEL LoS (excl Well Babies)	Jan-25	4.2	4.0	3.9	
% of Patients With No Criteria to Reside	Jan-25	20.3%	10.0%	22.8%	
Discharges Before Noon	Jan-25	20.6%	20.0%	17.9%	
G&A Bed Occupancy	Jan-25	98.9%	92.0%	98.0%	
Patients Whose Operation Was Cancelled	Jan-25	0.8%	0.8%	0.9%	
RTT % less than 18 weeks	Jan-25	59.0%	92.0%	59.0%	
RTT 65+	Jan-25	102	0	102	
% of E-discharge Summaries Sent Within 24 Hours	Jan-25	83.4%	90.0%	83.5%	
OP Letters to GP Within 7 Days	Dec-24	32.5%	90.0%	62.2%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jan-25	87.8%	85.0%	87.8%	
Mandatory Training	Jan-25	87.2%	85.0%	87.2%	
Sickness: All Staff Sickness Rate	Jan-25	7.3%	5.0%	6.0%	
Staffing: Turnover rate	Jan-25	0.6%	1.1%	0.9%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Jan-25				
Cash Balances - Days to Cover Operating Expenses	Jan-25				
Reported Surplus/Deficit (000's)	Jan-25				

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	26 February 2025
Agenda Item	**TB25/014 (7.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the four Executive Committee meetings held in January 2025		
Committee Chair	Rob Cooper, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were four Executive Committee meetings held in January 2025. At every meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. At each meeting, the weekly vacancy control panel decisions were also reported.		
09 January 2025		
Month 9 finance and activity position	• The Director of Finance and Information introduced an update on elective activity and income against the 2024/25 plan and detailed the challenges for Q4. • Committee discussed the recommendations from Productive Partners to improve theatre utilisation across MWL	Assurance
Quarterly Procedural Document Report	• The Acting Director of Nursing, Midwifery and Governance introduced the report. The number of procedural documents overdue for review and harmonisation were gradually reducing, with 51 approved since the last report. • 235 procedural documents had now been harmonised from the two legacy trusts. • The Committee supported the monthly reporting to Directors, as the most effective way of maintaining progress.	Assurance
Performance Management Framework	• The Chief Executive led a discussion on the plans for performance management of the Divisions and how the Premium Payments Scrutiny Council agreed actions could be monitored. A monthly Performance Management meeting with the divisions would be put in place from April, as part of the Executive Committee workplan. Team to Team meetings would continue on a quarterly basis for wider divisional engagement.	Assurance

Employee of the Month (EOTM)	• The Director of Corporate Services presented the nominations for EOTM, and Committee selected the recipients for December and January.	Assurance
Critical Incident - Whiston Hospital Emergency Department	• Committee discussed the critical incident that had been called on 02 January 2025 and noted the improved position and plans to step down the incident in agreement with the Integrated Care Board (ICB) and NHSE.	Assurance
16 January 2025		
CNST Maternity Incentive Scheme (MIS) year 6	• The Acting Director of Nursing, Midwifery and Governance introduced the report which detailed the Trust position in relation to each of the ten MIS safety actions. • The Committee received assurance of the evidence supporting a declaration of compliance for each safety action. • The report was also due to be presented to the Quality Committee ahead of the Board declaration being approved at the January Board meeting, which would be attended by members of the Local Maternity and Neonatal System.	Approval
Urgent and Emergency Care (UEC)National Patient Survey Results	• The Acting Director of Nursing, Midwifery and Governance presented the results of the survey of patients attending the Emergency Department (ED) between April and July 2024. • There had been a 28% response rate at MWL compared to 29% nationally • Although the Trust scores were “about the same” as other trusts across all areas of questioning there were some individual questions where the Trust score was “somewhat worse than expected” • These areas reflected patient frustration at the congestion and long waiting times in ED. • Committee reviewed the draft action plan and proposed changes to align the actions with the overall UEC improvement programme, as these would have the greatest impact on patient experience. • The updated report and action plan was approved for presentation to the Quality Committee.	Approval
Practice Development Nurse (PDN) Business Case	• The Acting Director of Nursing, Midwifery and Governance introduced the business case to substantively recruit a second Practice Development Nurse for Whiston ED. • Committee felt there was an opportunity to create a PDN structure across all the MWL EDs and that the benefits of this investment needed to be	Assurance

	identified, and tangible measures of success identified so benefits realisation could be tracked. Therefore, the team were asked to review and strengthen the business case.	
Histopathology Consultant Business Case	• The Director of Finance and Information introduced the case to recruit substantive consultants into roles that were currently being filled by agency locums. • The business case would result in a cost saving and was approved.	Approval
2025/26 Financial and Operational Planning	• The Director of Finance and Information presented the updated planning assumptions for 2025/26 based on information published by NHSE on elective recovery and local planning meetings with the ICB. It was acknowledged that these could change once the national planning guidance was published. • Based on the current assumptions, the Trust's underlying financial position being carried into 2025/26 would be a £79.5m deficit.	Assurance
Board Assurance Framework (BAF)	• The Director of Corporate Services presented the draft BAF, for review and agreement of changes to recommend to the Board.	Assurance
2024/25 Staff Vaccination Programme	• The Acting Director of HR reported that the uptake of the Covid-19 and Flu vaccine offers remained disappointing at 37.47% of frontline clinical staff for flu and 17.15% of frontline clinical staff for Covid-19, although these figures were in line with the regional and national position. • Committee discussed the apparent reluctance of clinical staff to be vaccinated considering recent high levels of flu, and what else could be done to support and encourage these staff. • It was noted that the Covid-19 vaccination programme had been extended to 31 January.	Assurance
Theatre Improvement Plan - Update	• The Committee received the monthly update on the Theatre Improvement Plan from the Surgical Division, which focused on the findings of the Productive Partners review and the subsequent action plan to increase theatre utilisation. • Progress had been made on several of the key metrics and the Committee received assurance on the actions planned to sustain and increase these. • The second NHSE Programme – Further Faster with the national Get it Right First Time (GiRFT)	Assurance

	team was also due to commence, which would focus on productivity.	
Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services presented the Council Assurance report. • There were 1,076 risks reported to the MWL risk register and 17 of these escalated to the Corporate Risk Register (CRR). • There were ten unapproved proposed corporate risks awaiting review and approval by the executive lead. • The RMC had received an update on the Quality Impact Assessment (QIA) process for cost improvement schemes and an assurance report from the Claims Governance Group.	Assurance
Cyber Security Report	• The Director of Informatics presented the report for the period to 31 December 2024. • All defence systems continued to perform well • The initial Data Security and Protection Toolkit (DSPT) submission for 2024/25 had been made and the annual penetration testing scheduled to take place in Q4.	Assurance
23 January 2025		
Carbapenamase Producing Enterobactererales (CPE) Business Case	• The Acting Director of Nursing, Midwifery and Governance introduced the business case from the Infection Prevention Control and Laboratory teams to increase CPE screening in line with national guidance due to the increase of CPE in the general population. • The business case reviewed options for increasing the screening capacity. • Committee supported the business case in principle but felt more work was required to understand the operational implications particularly on sites with low numbers of single rooms for patient isolation. • The team were asked to work with nursing and operational colleagues to develop the Standard Operating Procedures (SOPs) to provide assurance that the proposed screening regime could be operationalised, without unforeseen consequences for other patient groups. • The business case would be re-presented once this work had been completed.	Approval
Review of Falls	• The Deputy CEO presented the report which analysed all falls resulting in moderate or severe harm from April to September 2024.	Assurance

	• The analysis was multifactorial including age, sex, location, whether waiting for discharge, whether requiring supplementary care, if a falls assessment had been completed and the agreed care plan was in place at the time of the fall. • Of the 43 falls, 31 occurred on a ward, ten in ED and two in other settings. • The analysis did not indicate there was higher risk of falls occurring in side rooms. • The ward piloting decaffeinated drinks had recorded a reduction in falls compared to the previous 6-month period. • Committee commended the work that had been undertaken and requested that in future, patients are asked about the context if they fell i.e. were they trying to go to the bathroom unaided to see if there were any trends or themes • Another factor that could be tracked was whether the patient was noted to have experienced deconditioning at the time of the fall, as 23 of the patients were recorded as having no cognitive impairment but 17 of the falls had occurred within seven days of admission. • Committee felt that it may be possible to develop an algorithm of the different factors to predict the risk of a fall and the Director of Informatics undertook to explore any products already on the market that could support this.	
Complaints Annual Report 2023/24	• The Committee received the 2023/24 Complaints Annual report, which summarised the position for the previous year and the priority actions for 2024/25. This summarised the information from the quarterly complaints reports that had been submitted to Quality Committee during 2023/24.	Assurance
30 January 2025		
Draft Operational and Finance Plan 2025/26	• The Director of Finance and Information introduced the report which summarised the predicted financial position for 2025/26. • However, since the report had been produced the national planning guidance had been published, and the department were working through the guidance to assess if this changed the outline plan. • As expected, efficiency and productivity would be a key focus with further reductions in variable pay required.	Assurance

Rainhill Library	• The Director of Corporate Services presented a proposal to purchase the former Rainhill Library building from St Helens Council. • This was a shared site with Rainhill Clinic and would provide expansion or redevelopment opportunities that supported the Trust's estate strategy. • The business case was approved	Approved
Urgent and Emergency Care (UEC) Improvement Programme	• The Director of Strategy introduced the report which provided an update on the actions being taken to improve UEC performance and improve patient flow. • Ward A at Ormskirk hospital would provide 17 step-down beds once the refurbishment works were completed, which would allow the reconfiguration of beds at Southport hospital. • The staffing model presented was reviewed by the Committee and further clarification sought before this could be approved. • In relation to Whiston hospital, the trial with PC24 had not made the difference expected because of the acuity and complexity of patients attending the ED. • The remaining RESET actions were resulting in improvements and further analysis was requested to understand the true costs. The importance of full Place engagement was emphasised.	Assurance
Staff Vaccination Programme Update	• The Acting Director of HR presented the fortnightly update on the staff vaccination programme. • The uptake figures remained disappointingly low for the Trust, the ICB and nationally. • However, it was noted that due to changes in definitions and the Trust headcount, MWL had still delivered more vaccines to more people than last year. • The Health Work and Wellbeing (HWWB) team were analysing sickness data and correlating this with teams or departments with the lowest vaccine uptake and developing plans for the final weeks of the 2024/25 campaign.	Assurance
Trust Board Agenda – February 2025	• The Director of Corporate Services presented the draft Trust board agenda, based on the agreed workplan for review. • The Committee reviewed the Employee of the Month (EOTM) nominations received during	Assurance

	January and agreed the EOTM recipient for February.	

Alerts:

None

Decisions and Recommendations:

Investment decisions taken by the Committee during January 2025:

- Business case to appoint substantive Histopathology Consultants
- The capital purchase of the former Rainhill Library building

Committee/ Assurance Report			
Title of Meeting	**Trust Board**	**Date**	26 February 2025
Agenda Item	**TB25/014 (7.2)**		
Committee being reported	Audit Committee		
Date of Meeting	19 February 2025		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Part 1 – Open Items		
External Audit Progress Report	Grant Thornton (GT) informed Committee members that Sarah Ironmonger is the new Engagement Lead for 2024/25. GT updated Committee members that planning for the 2024/25 external audit had started and good progress is being made so far. GT will document the planning exercise and present to management in March 2025. This will be brought to Audit Committee in April 2025. GT were planning to work to the national timetable and issue an audit report and opinion in June 2025. Value for Money (VfM) work will be conducted by a specialist VfM team and the plan was also to complete this by June 2025.	Assurance
Informing the 2024/25 Audit Risk Assessment – Management Responses	The report detailing the audit risk assessment and managements responses was presented. The Committee was assured that the document was largely unchanged from the previous year (2024/25 excluding references to the StHK and S&O Transaction) and no significant new risks had emerged.	Assurance
Internal Audit Report	MIAA summarised the internal audit progress reports key messages section. Four reports have been finalised, three have received substantial assurance and one received high assurance. Eight reports were currently in	Assurance

	progress from the 2024/25 internal audit programme.	
MWL Audit Log	Committee received the audit log report, which highlighted key movements on the audit log, both in relation to internal and external audit recommendations.	Assurance
Anti-Fraud Annual Report	Committee received the anti-fraud progress report. 13 anti-fraud referrals had been brought forward from October 2024, and nine new referrals had been received since the last Audit Committee. 12 referrals had been converted to investigations and four referrals had been closed. One investigation had been brought forward from October 2024. 12 new investigations had been commenced, and three investigations had been closed. Budget holder Conflict of interest (COI) return percentage completion rate had improved to 50% but remained below the target of 80% (and rated amber). Activities planned to improve performance were discussed.	Assurance
Audit Committee Annual Workplan and Meeting Dates	The Committee received the proposed committee workplan for 2025/26. GT recommended a change, moving the Auditors Annual Report and Audit Findings Report and Opinion to June 2025. Subject to this change, the workplan was approved.	Approve
Financial Reports	The Losses and Special Payments report was presented. Total losses identified year to date were £334k (compared to £409k for the same period in 2023/24). The Aged Debt report was noted. Committee requested a detailed analysis of the aged debt and the actions being taken to clear some of the older invoices.	Assurance

	The tenders and quotation waivers report was noted, and committee discussed how the numbers benchmarked against neighbouring organisations.	
Title	**Description**	**Purpose**
Part 2 – Closed Items		
External Audit Contract 2025/26	DDoF summarised the Trust's current position regarding its external audit contract for 2025/26 onwards and sought approval from the Committee to continue the described procurement exercise.	Approve
Alerts:		
None		
Decisions and Recommendation(s):		
None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	26 February 2025
Agenda Item	**TB25/014 (7.3)**		
Committee being reported	Quality Committee		
Date of Meeting	18 February 2025		
Committee Chair	Gill Brown, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Matters arising/Action Log	The outstanding actions were reviewed and progress noted.	Assurance
Quality Committee Corporate Performance Report (CPR)	• Committee acknowledged the operational and clinical challenges over the month of January. • One Never event (January 2025) - wrong site anaesthetic block. Three Never Events 2024/25 year to date (YTD), no patient harms. Focused review with clinical area and site identified. Policies and processes supporting patient safety checks refreshed and human factor elements noted with assurance through ongoing audits across MWL. • Falls: Moderate / severe harm falls - improved position in Jan 2025 with focused actions on medication reviews and decaffeinated drinks. Business case for supplementary care approved for substantive staff to five ward areas. Falls external review to be commissioned. • Venous Thromboembolism (VTE): Improvement actions remain focused on the Whiston site, with rollout planned across the Trust. Committee received confirmation VTE risk assessment now on Electronic Prescribing and Medicines Administration (EPMA) with confidence for improved outcomes with monitoring via Clinical Effectiveness Committee. Single EPMA for all sites being progressed. • Nutrition: Some improvement against metrics in January 2025 noted. Dietetic referrals remain a	Assurance

	continued focus. Dietetic IT referral process under review. • Mortality: YTD Hospital Standardised Mortality Ratio (HSMR) below 100. Latest figures (June 2024) - HSMR has increased but within tolerance levels of monthly variation. All deaths reviewed and no areas of concern highlighted. Summary Hospital-level Mortality Indicator - Deaths associated with hospitalisation (SHIMI) data lower than statistically expected. • Maternity: zero babies sent for cooling, zero perinatal and neonatal mortality for Jan 2025. • 100% Compliance with 1:1 Care • 100% Compliance with Supernumerary Delivery Suite Coordinator. • Induction of labour - metrics now reflecting consistency across MWL. • Infection Prevention and Control (IPC): zero MRSA bacteraemia's in month, however five YTD with shared learning from these incidents noted. • Six Methicillin-sensitive Staphylococcus Aureus bacteraemia (MSSA), deep dive ongoing. • Concerns regarding compliance against clinical practice noted, ongoing improvement work noted, and a Trust wide campaign is planned. • Level 2 Aseptic Non Touch Technique (ANTT) compliance remains challenging - divisional areas identified for increased focus and engagement with clinical teams. • Committee requested update regarding outpatient discharge letters process, due to deterioration in performance. Assurance noted regarding urgent letters (i.e. within 48hrs) are being actioned. • Committee noted on-going discussions at Executive Team meetings regarding Sepsis metrics.	

Mandatory Training Compliance Report Q3 2024/25	• Alignment of mandatory training and training needs analysis (TNA) completed. Workforce team now modelling and forecasting to propose a safe implementation plan. Improved compliance expected. Good engagement from the divisions reported. • Mandatory and Compulsory Skills Training: Maintaining above 85% compliance against Trust target with areas of focus detailed and support for individuals noted. Subject matter experts supporting alternative ways of delivering training to improve trajectory. • Deep dive into non-compliant areas/individuals with assurance provided to the Committee regarding improvement plans. • Review of models and mode for delivery for mandatory training is on-going. • ANTT training needs analysis report to be presented to Executive Committee for approval. • Committee were advised on action to review medical staffing compliance through Executive Committee review. • Committee acknowledged and commended the work to date.	Assurance
Patient Experience Report (including. Council Chairs Report).	• Approved action plans in progress against national surveys received. Committee advised on initial results from the survey provider received for the 2024 Children and Young People survey – Care Quality Commission (CQC) publication of nationally benchmarked results expected in March 2025. • 2024 Cancer Patient Experience survey in progress - no confirmation yet of date for publication of results. • 2024 Maternity Survey - progress being monitored via the Trust Patient Experience Council. Additional local survey reporting to	Assurance

	assure actions are impacting change, ongoing monitoring through Executive Committee. • Patient Experience and Inclusion Strategy received. Committee requested assurance and clarity against measurement of success of the strategy and the measures within it to assure organisational learning. Strategy to be presented to Executive Committee for approval. • Committee informed that Trust visiting hours are under consultation.	
Patient Safety Report (including Council Chair's Report)	• 11 PSII open with investigations on track. • Two PSII commissioned in November and December 2024. • 5,866 incidents for the months of November and December with pressure ulcers remaining the highest category of incidents reported. No significant lapses in care noted. • InPhase (Datix replacement) implementation launch in March 2025 with assurance provided against incident migration from Datix system. • VTE Q3 compliance: improved position, noting EPMA as a key driver. Assurance VTE themes reviewed and improvement plan in place with reflections going forward via Patient Safety Incident Response Framework (PSIRF). • Two StEIS incidents reported with assurance against actions noted. • Patient safety training ongoing including PSIRF methodology. • VTE - actions in place to improve compliance and risk assessment.	Assurance
Monitoring of Annual Trust Objectives aligned to Quality Committee Q3 Update	• Urgent and Emergency Care: Triage (Baseline Observations) remains below target in Q3 for MWL. Interventions in place and assurances given for review of actions. • Appropriate escalation of patients who trigger on National Early Warning Score (NEWS)	Assurance

	achieved, however NEWS observations on time remains challenging. • Sepsis screening: Diagnosis of patients with sepsis achieved but timely administration of antibiotics within one hour of diagnosis still challenging. National Institute for Health and Care Excellence (NICE) guidance has recently changed and improvement with compliance is anticipated with the new guidance. • IPC - ANTT level 1 compliance - improved and sustained compliance. Level 2 compliance remains below target and close monitoring is on-going. • Methicillin-Resistant Staphylococcus Aureus (MRSA) screening compliance: positive in Q3. Visual Infusion Phlebitis score (VIP) compliance not sustained despite improvements in Q2. Additional focus required. • Hydration: On track to achieve. • Discharge: Patients discharged before noon and discharge patient information - objective achieved in Q3. Further work required for Take Home Medication (TTOs) and patient experience. • Patient Experience in Maternity – local surveys planned based on national key lines of enquiry to assess impact on improvement actions. Maternity Strategy to be launched in Q1. • Acknowledged some of the objectives required to continue into 2025/26 particularly regarding urgent care, patient flow and IPC.	
Maternity & Neonatal Services Quarterly Report Q3	• Confirmation of compliance with Clinical Negligence Scheme for Trusts (CNST) Year 6 approved by Board in January 2025 noted. Year 7 CNST compliance objectives to be launched shortly. • Smoking referrals 100% and improved breastfeeding rates year to date noted. Infant feeding team on Whiston site strengthened.	Assurance

	• Perinatal Mortality Reports for both Whiston & Ormskirk (Q1 & Q2) included in the pack of reports for this Q3 update. Ten reportable deaths in Q3. • Serious Reportable Incidents (MNSI) - two new cases reported. Both cases have had initial reviews with no immediate issues identified. • Neonatal medication incident – 11 in Q3. All categorised as no harm. Committee requested further assurance against medication incidents with no harm. • No never events in Q3. • Saving Babies' Lives – Q3 quarterly Local Maternity and Neonatal System (LMNS) validated data received noting Whiston 87% Ormskirk 91%. Committee assured Trust remains compliant for CNST. • Maternity Strategy planned launch in the new financial year. • Update received regarding CQC Improvement plan and assurance regarding improvement actions. • Maternity and Neonatal Voices Partnership (MNVP): 15 Steps Action Plan - Ormskirk fully completed all actions, Whiston site working well towards completion of actions. • Complaint responses actioned and themes noted with assurance received against actions. • One new claim received in Q3. • Maternity red flags - reviews completed with no themes or trends noted, other than periods of high activity in Triage. • 100% compliance with 1:1 care and supernumerary Delivery Suite Shift Co-ordinator across MWL. • Maternity Staffing / workforce reports for Ormskirk and Whiston noted. • Workforce: funded establishment aligned with Birthrate+ across MWL. • Neonatal workforce – MWL meets British Association of Perinatal Medicine (BAPM) standards. Qualified in Speciality (QIS) training programme - plan in place to achieve 65% compliance in year. • UNICEF accreditation stage 2 - Achieved at Ormskirk with Whiston working towards accreditation. Ormskirk Team congratulated.	

	• NHSE Three-Year Delivery Plan - Maternity Provider Oversight Panel (MPOP) noted – Consequences of neonatal department closures requested by the Committee. • Committee noted recommendation by Operational Delivery Networks (ODN) -Regional review of neonatal services to reconfigure and consolidate pathways with local review at Executive level ongoing. • Badgernet implementation - confirmed with timescale proposed. • Neonatal Nursing Staff sickness - Ormskirk attributable to seasonal issues. Whiston longer term absence with resolutions ongoing. Health, Work and Well Being (HWWB) support to neonatal staff acknowledged based against ongoing and recent national media coverage – agreement to review with OD team.	
Any Other Business	• None	

Alerts:

- None

Decisions and Recommendation(s):

The Board is recommended to note the report.

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	19 February 2025
Agenda Item	**TB25/014 (7.4)**		
Committee being reported	Strategic People Committee		
Date of Meeting	19 February 2025		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Minutes of the previous meeting	The Committee reviewed the minutes of the meeting held on the 22 January 2025 and approved them as a correct and accurate record of proceedings.	Decision
Action Log and Matters Arising	The Committee reviewed the outstanding and approved the completed actions.	Assurance
Workforce Dashboard	The Corporate Performance Report (CPR) dashboard with the following points noted that the MWL combined workforce dashboard identifies: • Appraisals - appraisal compliance is 86.9% • Mandatory Training - the Trust continues to exceed its target for mandatory training at 87.7%. • Sickness - in-month sickness increased during January to 7.11% (December 6.69%) against a 5% target. • Vacancies - vacancy rate has remained at 7% against a target of 8%. The largest vacancy gap is within the Healthcare Assistant (HCA) staff group at 11.3% against a target of 8%. The pipeline for HCAs in January is 85.26 Full Time Equivalent (FTE) with a further recruitment event scheduled for 15 February. • Average time to recruit - average time of recruit has increased in January; increased to 63.2 days against a target of 40 days. There were significant delays in January for time to hire primarily due to the transition from the Cohort Occupational Health system to the new Civica Occupational Health Cloud Management Software System (OPAS-G2). The Cohort system was phased out in November 2024 leading to a temporary paper-based process that caused substantial delays. As a result, the Trust has a backlog of candidates	Assurance

	awaiting clearance from November 2024 to January 2025, which has, in turn, impacted the processing of new candidates through the OPAS-G2 system. The Occupational Health Team has implemented a recovery plan and expects to return to normal Key Performance Indicators (KPI) levels by the end of February. • Turnover - in-month turnover is 0.6% against a target of 1.1% with 12-month rolling turnover is 11.5% against a target of 13.2%. • Occupational Health – the KPI's reported are from November. Following implementation of OPAS-G2 monthly reporting will resume.	
Employee Relations Annual Update Trust & Lead Employer 2024	An overview was provided of Employee Relations matters in the scope of the terms of reference of the Employee Relations Oversight Group Cases against recent publications by professional bodies, the national landscape for employee relations on how practice can be improved to reduce time taken to complete investigations, ensuring that the Trust promotes fairness, proportionality and consistency, and takes steps to improve the experience of all parties involved in formal processes. The paper considered how this relates to the Trust's handling of employee relations matters and provided the opportunity for stakeholder engagement on what actions should be taken to continue to improve the Trusts people practices. The themes identified in the paper align in particular to two of the pillars of the NHS and MWL's People Plan: • **Looking After Our People** particularly the actions, we must all take to keep our people safe, healthy and well – both physically and psychologically. • **Belonging in the NHS** highlighting the support and action needed to create an organisational culture where everyone feels they belong. Both the Trust and Lead Employer have made improvements in reducing case length over the course of 2024. Further work is required to understand which actions taken have had the most significant impact to know how to further improve case management process in the future. Case	

	length reduction during 2024 have been achieved through: • Exploring informal resolution of conduct concerns from the outset, where appropriate. • Increasing the use of fast-track process where individuals do not contest conduct concerns. • Handling behavioural concerns through the NHS Resolution, Performance Practitioner Advice Service Behavioural Assessments (Lead Employer). • Reviewing the structures of both Trust HR and Lead Employer to ensure senior oversight on cases and increased capacity moving forward into 2025/26. • Encouraging informal resolution of Grievance and Respect and Dignity at Work cases with the support of facilitated discussion or Mediation. There was recognition that the implementation of the 72 hour review process had been positive, however based upon feedback from managers it has been recognised that there is a need to introduce comprehensive guidance for the completion of 72-hour reviews for managers to ensure that that they feel confident and equipped to complete 72-hour reviews in a timely manner as concerns arise. Training will also be of benefit, specifically around what actions to take when Disciplinary, Grievance and Respect and Dignity at Work (RDAW) concerns arise within the workforce. It was noted that it will also be important to include the risks associated with not addressing concerns as they arise, for example repeated poor conduct, and the impact on patient care, colleagues and wider teams. Grievances and RDAW cases represent a substantial proportion of the Trust and Lead Employer caseloads. Both HR teams use well-established early resolution strategies, such as mediation and facilitated discussions, where appropriate. Delays that occur are due to only a limited supply of training mediators and the capacity of those people to support cases when required. The review of complex and lengthy grievance and RDAW cases in 2024 has highlighted the continued need for timely organisational development (OD) interventions. Relationship breakdowns within	

	teams, often involving a single individual or small group, have been identified as a recurring issue which be a focus of attention in 2025/26. There was recognition that the volume of complex cases is rising, e.g. domestic and child abuse, especially those involving safeguarding or external agencies (such as the police and social care). There is also a trend of cases involving the use of recreational drugs would benefit from a focus on staff support and prevention awareness to avoid issues progressing into formal cases in the future. The following points have been identified as being potentially beneficial to all those involved in employee relations processes: • **Promoting values and behaviours:** Support managers and staff to uphold these standards, with training on handling low-level concerns. • **Mediation training:** Invest in training more mediators and ensure they have time to carry out mediation effectively for early, informal conflict resolution. • **72-hour review process:** Train managers on completing the 72-hour review and ensure accountability for meeting the timeframe. • **Investigation training:** Provide training for Investigating Officers, and Case Managers, clarifying their roles and allocate protected time to complete investigations promptly. • **Employee Relations Oversight Group (EROG) data review:** Review the information provided through EROG to ensure it meets organisational requirements and highlights key issues relevant for 2025. • **Professional supervision:** Develop a process to support for the HR team members handling complex and potentially distressing cases.	
Assurance Reports from Subgroup(s)	The Strategic People Committee noted the Assurance Reports from the People Performance Council and the Valuing our People Council.	Assurance
Items for Escalation to Trust Board	There were no items to escalate to the Trust Board	Assurance
Any Other Business	Not applicable	Assurance

Effectiveness of Meeting	The Committee indicated this meeting has been effectively chaired.	Assurance
Alerts:		
None		
Decisions and Recommendation(s):		
None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	26 February 2025
Agenda Item	**TB25/014 (7.5)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	20 February 2025		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Director of Finance (DoF) Update	• NHSE reporting an increase in productivity of 2.4% in 2024/25, this is using the implied productivity metrics shared last month. • NHSE Board confident in delivering 2024/25 plan despite provider sector reporting £1bn pressure • Integrated Care Board (ICB) planning process involving multiple meetings; DoF/ Chief Executive (CE), CE and Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) meetings • ICB draft plans contains significant deficit with only one provider reporting a surplus plan.	Assurance
Planning Part 1: National Guidance and MWL Plan	• Update given to Committee on the national guidance published 30 January and what it means for MWL including overview of national priorities and how these link in to existing workstreams within the Trust. • Overview of productivity and efficiency measures shared by the national team to support the identification of improvements to support the planning process. Expectation of a 2% real terms reduction in costs and a 5% productivity improvement. • Expectation of a 5% improvement in Referral to Treatment (RTT) despite Elective Recovery Fund (ERF) reducing by circa 3%, potential cap but values only released in June. • MWL draft plan for 2025/26 including finance, workforce and performance metrics was presented including all known non-recurrent	Assurance

	items within the plan alongside emerging issues. • Significant financial challenge across the Trust and System, work ongoing to identify opportunities to improve. • Discussion held around known and emerging risks, what mitigations are currently in place and strategic opportunities. • Trust planning approach described along with work at a system level.	
Integrated Performance Report Month 10 2024/25	• Bed occupancy across MWL continues to be significantly higher than the target of 92% and in January averaged 98.6%. • Average length of stay for emergency admissions is high at 8.23, 9.12 at legacy S&O and 8 at legacy STHK, the impact of non-criteria to reside (NCTR) patients remains high in January, being 18.9% at Organisation level (20.3% legacy STHK and 16.4% legacyS&O). • 4-Hour performance decreased in January achieving 73.1% (all types), national performance 73% and providers across Cheshire and Merseyside (C&M) averaging 72.9%. • Complex discharge panel to bring system partners together to ensure long length of stay patients are able to leave hospital faster. Trajectory for system partners developed for NCTR to focus efforts on reducing the numbers. • 18 Week performance in January for MWL was 60.7%, legacy S&O 64.3% and legacy STHK 59.0%. National Performance (latest month November) was 58.9% and C&M regional performance was 56.7% • The Trust had 2,223 52-week waiters at the end of January, 144 65 week waiters and four 78 week waiters. • Diagnostic performance in January for MWL was below target at 93.6%, legacy S&O 94.7% and legacy STHK 93.1%. • Cancer performance for MWL in December increased to 78.2% for the 28-day standard but decreased to 75.7% for the 62 day standard.	Assurance

Finance Report Month 10 2024/25	• The Trust is reporting a deficit of £13.1m which is £5.3m better than the revised plan due to the recognition of planned transaction support offset by the impact of industrial action and pressures following the critical incident. • The Trust's combined 2024/25 Cost Improvement Programme (CIP) target is £48m of which £11.8m is non-recurrent. As at Month 10, the Trust has transacted CIP of £41.6m in year and £33.7m recurrently. • At Month 10, agency spend is £19.1m to date, 3.6% of total pay costs. Premium Payment Scrutiny Council review and address the drivers of agency costs with actions taken through executive committee. • The Trust has a closing cash balance of £3.4m at Month 10. The Trust anticipates a closing cash balance of c.£2.7m as per plan. • Better Payment Practice Code (BPPC) has not been achieved for non NHS suppliers but has been impacted by a large volume of small value agency invoices, however it is on an improving trajectory. • The capital plan for the year is £48.4m (including Public Finance Initiative (PFI) Lifecycle). Spend to date is £27.2m as plan.	Assurance
Month 10 2024/25 CIP Programme Update Medicine and Urgent Care Division CIP update	• Total targets for 2024/25 is £48m in year and £36.2m recurrently. • At month 10 there is £41.6m transacted with a further £1m of delivered/low risk schemes to be transacted (89% of the £48m target) and £33.7m recurrent transacted with a further £0.8m delivered/low risk schemes to be transacted (95% of the £36.2m target). • Schemes identified in 2024/25 to date are £61.2m with £60.1m recurrent. Focus is on delivering remaining balance of the 2024/25 plan. Schemes not delivered in year will be rolled forward as part of the CIP programme to support 2025/26 plans. • Division CIP update provided including overview of governance process to provide assurance.	Assurance

Cancer Performance	• Performance across tumour sites shared for the Trust split by location and the ICB. MWL performance higher than the ICB performance overall and for five of the nine sites • Overview of historic trends and links to fragile services and activity delivered alongside other organisations • Tumour site specific action plans developed on a continuing basis to ensure plans are in place to improve performance. Deep dives commenced to update and ensure these action plans are delivering.	Assurance
Assurance Reports from Subgroups:	• Procurement Council (no meeting in Feb) • CIP Council • Capital Planning Council • Estates & Facilities Management Council • IM&T Council update	Assurance
Alerts		
None		
Decisions and Recommendation(s):		
None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	26 February 2025
Agenda Item	**TB25/015**			
Report Title	Maternity and Neonatal Services Assurance Report (Quarter 3)			
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Presenting Officer	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

To update and inform the Board regarding the priorities and progress of the Maternity and Neonatal Services across Mersey and West Lancashire Teaching Hospitals.

Executive Summary

A summary of the progress within maternity and neonatal services at MWL that includes:

- Perinatal Mortality
- Serious Incidents, Maternity and Newborn Safety Investigation (MNSI)
- Neonatal Medication incidents
- Saving Babies Lives (SBLv3) Continuous improvement and working towards full compliance supported and monitored by the Local Maternity and Neonatal System (LMNS)
- Care Quality Commission (CQC) Improvement Plan Update
- Patient experience, complaints and 15 steps action plans
- Workforce including biannual maternity staffing papers.
- Update on the progress of the Three Year Delivery Plan update

Financial Implications

Awareness of potential future investment into the Maternity Services

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to note the Maternity and Neonatal Services Assurance Report (Quarter 3)

Strategic Objectives

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

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

1. Maternity Incentive Scheme (MIS)

MIS year 6 evidence paper was presented to Quality committee and Trust Board in January 2025 alongside a presentation delivered by the Divisional Director of Midwifery and the Divisional Medical Director. The LMNS were in attendance at the presentation provided to the Board on the 29 January 2025 who confirmed that the ICB had approved the evidence reviewed for safety actions 3,4,5,6,7,8 and 9. Safety actions 1,2 and 10 are approved via external sources included MBRRACE and NHSR.

Evidence was provided for the 10 safety actions and Board were satisfied that the evidence met the required safety actions and sub requirements and approved the declaration of full compliance to be submitted.

The Board declaration will signed by the CEO of the Trust and the accountable officer for the integrated Care System (ICB) and submitted before the deadline of 12 noon on the 03 March 2025.

Evidence continues to be collated for MIS in anticipation of the Year 7 being published as various safety actions will continue. Safety action 8 (Training) continues as the required training data reporting timescales commenced on 1st December 2024.

2. Quality and Safety

2.1. Clinical Outcomes/ Dashboard

Maternity and Neonatal Dashboards

Performance is monitored via our local and regional dashboards. Regional and local clinical dashboards are monitored via local governance and presented via the IPR at Quality Committee.

Current areas of focus:

- Smoking - A continued focus on referral of women who smoke at booking to stop smoking services aimed at supporting a smoke free pregnancy and reducing the % of smokers at the time of delivery. Focussed work to improve compliance continues and saw 100% compliance in December 2024.
- Breastfeeding – The % of women initiating breastfeeding in December at MWL was 67.8% with a year-to-date rate of 61.8%. An improving trajectory continues with quality improvement projects implemented alongside enhanced staff training within the division.

2.2. Perinatal Mortality

Perinatal mortality data forms part of MIS Safety action 1. Details regarding the cases is presented to Safety Champions, Quality Committee and via the Patient Safety report at Trust Board.

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

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

For the Q3 reporting period (2024/25) there were 10 reportable deaths.

Quarter 3: 2024/25	Total numbers	
October 2024	5	3 stillbirths at MWL 1 stillbirth elsewhere. 1 neonatal death born at MWL but died elsewhere
November 2024	3	1 neonatal death at MWL. 1 neonatal death elsewhere. 1 stillbirth elsewhere. Initially booked at MWL but care transferred to a specialist unit.
December 2024	2	2 stillbirths at MWL

All cases have undergone a multidisciplinary review with the commencement of the PMRT process. Care was reviewed and assessed for all cases using the MBRRACE categorisation.

There was a stillbirth in October where antenatal care was provided by this trust. A PMRT panel at the Trust where the stillbirth occurred will be convened in which MWL will participate.

For these cases initial reviews have been undertaken that did not identify and urgent or immediate concerns at MWL. During these reviews issues that would not have made a difference to the outcome may be identified. Actions are addressed and shared learning is undertaken to enable improvement to be undertaken. There was one case in November that had an action for NWAS to review obstetric emergency and NLS training for their staff.

Perinatal mortality is detailed within the maternity and neonatal reports and the full perinatal mortality reports for Q1 and Q2 2024/25 were provided to the February 2025 Quality Committee.

2.3. Serious Incidents

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

Serious Reportable Incidents
Serious incidents (SIs) are reported as they occur and are evidenced on the regional dashboard which is updated monthly. Serious incidents are additionally detailed within the patient safety report presented at Quality Committee.

Maternity Q3 2024/25		
	Whiston	**Ormskirk**
October 2024	No Incidents	No Incidents
November 2024	1 x day 5 neonatal death – MNSI reportable	No Incidents
December 2024	1 x Therapeutic Cooling – MNSI reportable	No Incidents

The Neonatal death in November is the same case as detailed in section 2.2 above which will undergo a PMRT review. MWL reported this case to MNSI as per guidance.

There was one therapeutic cooling case. The baby was transferred to the tertiary referral unit and at the end of Q3, the MRI scan result was outstanding. Both cases had initial reviews and there were no immediate issues identified.

In January 2025, the Trust board received an aggregated incident, complaints and claims report for Q3 that identified labour and delivery as the 5th most common category reported on the Ormskirk site. Within the incident reporting system, there are multiple sub cause groups within the labour and birth category, such as PPH, 3rd and 4th degree tears, shoulder dystocias and unexpected admissions to the neonatal unit >= 37 weeks etc.

Within this reporting period for Ormskirk there were 194 incidents submitted under the labour and delivery category. 92 of these incidents related to blood loss of 500-999mls. This category was added as a trigger for reporting onto the Ormskirk incident reporting system in August 2024 and accounts for the increase in reported incidents.

A review of incidents reported on the Whiston site was undertaken for the same reporting period under the category of labour and delivery. There were 111 incidents for Q3 and of these, 23 related to blood loss of 1500mls or more which are required to be reported and reviewed in accordance with the Clinical Quality Improvement Metrics (CQIM) requirement for any blood loss of 1500mls or more.

A review of the maternity electronic system on the Whiston site was undertaken to identify the numbers of women who had a blood loss between 500-999mls and identified that there were 305 women within Q3. If a Datix had been completed similar to the Ormskirk site for these women there would have been 416 incidents in total which would have made Whiston maternity appear as the 3rd most common category. Although Whiston do not report blood loss less that 1500mls unless clinically indicated, audits are undertaken to ensure appropriate management is undertaken.

Ormskirk added this additional field in a proactive move due to being a maternity service with no blood bank or level 2 or level 3 services on site. There had been intelligence that CQC were focussing on evidence of how maternity services with smaller numbers of births report and manage smaller blood loss. Each reported Datix has an incident review to ensure appropriate management.

2.4. Maternity and Neonatal Safety Investigations

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

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

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

All investigations accepted by MNSI are reported on STEIS as a serious incident. Cases returned to the Trust are investigated with a full MDT review including an external representative from the Cheshire and Merseyside system.

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

Cases to Date April 2019 to December 2024	Whiston	Ormskirk	Total
Total Referrals	54	16	70
Referrals / Cases Returned to the Trust / Rejected	21	6	27
Total Investigations to Date	31	10	41
Total Investigations Accepted	31	10	41
Total HSIB Investigations Completed	31	10	41
Current Active Cases	2	0	2

The two new cases are the incidents identified in the serious incident section above. The referrals are still in the MNSI triage process and had not been accepted by the end of Q3. One case due to an ongoing police investigation and the second case pending findings of the MRI findings from the tertiary referral unit.

2.5. Neonatal medication Incidents

MWL Neonatal Medication Errors (as identified via DATIX) Q3 (2024/2025)

During Q3 report period (2024/2025) there has been 11 medication incidents within the Neonatal Units (NNU) of MWL. Medicine incidents during this quarter were categorised as either medication prescribing or administration errors. All incidents were categorised as no harm caused incidents.

Number of medication incidents			
Location	Q1	Q2	Q3
Ormskirk	10	1	6
Whiston	4	10	5
Total	14	11	11

Category	Q1	Q2	Q3
Medication - storing	7.1%	18.2%	0%
Medication - prescribing	14.2%	18.2%	45.45%
Medication - administration	50%	63.6%	45.45%
Medication - delivery	14.2%	0%	9.1%
Medication - preparing	14.2%	0%	0%

Key findings/themes during this period:

- Unintentional omission or delay of medicines
- Miscommunication between staff and parents leading to omitted medicines
- Prescribing TPN issues for Ormskirk

Recommendations:

- Introduction a new prescription chart for NNU across both sites which includes a gentamicin prescription page which went live on 03/02/25
- Review current neonatal sepsis pathway which will commence following implementation of new prescription charts
- Introduction BBraun drug library to aid administration of medication and reduce the number of incidents. Expected completion date March 2025
- Introduction IV drug monographs. Total of 22/30 monographs ratified and in use and uploaded to the Trust intranet
- Introduction of Numeta G13% and G16% TPN guideline which will help reduce the risk of errors, infection and medication errors associated with compounded TPN. It will replace ITH ordering of TPN for Ormskirk making it more cost effective and will allow babies to receive lipid soon after birth and improve long term growth outcomes. Completed and pending approval.
- Continued neonatal education and staff induction contributions from pharmacy across MWL.

2.6. Saving Babies Lives (SBL) Care Bundle

The requirement to be on track with compliance with all elements of the Saving Babies' Lives Care Bundle Version 3 is a requirement for safety action 6 for MIS year 5.

Each maternity site has a SBL lead alongside leads for each element. All audit data to evidence compliance with the standards required for the SBL elements is collated by the leads for each individual element and overseen by the governance team, supported by the audit team, for both sites. The two sites are working towards ensuring the process is harmonised.

Both Ormskirk and Whiston services are compliant from an MIS perspective and continue to work towards full compliance.

Evidence is collated and presented at the governance meetings who additionally review the action plan progress for each element. Uploading of verified evidence is submitted to the LMNS on the Futures platform for LMNS review. Regular quarterly meetings with the LMNS are in place to monitor and review current evidence alongside action plan progress. Following these meetings, the LMNS review all evidence and provide each Trust with their compliance ratings.

The Q3 quarterly LMNS improvement discussion meeting held in December 24 has identified a reduction in overall compliance to 87% for the Whiston site and 91% for the Ormskirk site.

The tables below provide the compliance progress from Q2 2023/24 to end of Q3 2024/25:

Whiston site

	Baseline assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5
Review Quarter	Q2	Q3	Q4	Q1	Q2	Q3
Assurance review date	17/11/23	07/12/23	07/03/24	06/06/2024	17/09/2024	06/12/24
Element 1	10%	50%	60%	90%	100%	80%
Element 2	70%	75%	80%	85%	85%	90%
Element 3	50%	50%	100%	100%	100%	100%
Element 4	60%	100%	80%	60%	100%	100%
Element 5	37%	74%	93%	93%	93%	81%
Element 6	33%	67%	83%	100%	100%	100%
Total	40%	71%	83%	88%	93%	87%

Ormskirk site

	Baseline assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5
Review Quarter	Q2	Q3	Q4	Q1	Q2	Q3
Assurance review date	16/11/23	08/12/23	22/03/24	27/06/2024	17/09/2024	10/12/24
Element 1	60%	100%	100%	100%	100%	100%
Element 2	60%	75%	95%	100%	100%	100%
Element 3	0%	50%	100%	100%	100%	100%
Element 4	80%	100%	60%	80%	100%	80%
Element 5	26%	85%	96%	96%	100%	81%
Element 6	67%	83%	100%	100%	100%	100%
Total	47%	84%	94%	97%	100%	91%

The LMNS are still happy with the continued progress of MWL in implementing the care bundle with monitored action plans predominantly in relation to audits and documentation as identified below.

Element 1: Reducing Smoking in Pregnancy

Ormskirk site is fully complaint with Element 1 at 100% and will continue to evidence audits to demonstrate continued compliance.

Whiston site has reduced compliance with Element 1 at 80% in Q3. A detailed action plan has been implemented to improve trajectory of compliance to audits as this has reduced from the previous quarter. Themes of non- compliance with documentation has been identified and learning has been shared with the wider multidisciplinary team via multiple platforms including newsletter, safety huddles, staff learning pages, quality bus, global emails, MDT study days and individual emails to staff who are persistently non-complaint. The main issues relate to undertaking CO monitoring at every contact and entering a smoking quit date once agreed.

Improvements have been noted in both services in terms of the increased referrals to in house smoking cessation team resulting in 100% compliance in December 2024. Ongoing audits continue. Harmonisation of policies and implementation of guidance continues to ensure sustained improvement.

Element 2: Risk Assessment and Surveillance of Fetal Growth Restriction
Ormskirk demonstrate sustained compliance at 100% and Whiston had improved compliance at 90% from 85%. All recommendations have been implemented; however, work continues to achieve 100% compliance which relates to audits. Audits of measuring the fundal height for low-risk women were not completed only a sample for high-risk women which reduced compliance which has been rectified. An action plan to increase training compliance to 'Gap and Go' training has been implemented. The required compliance is 90% with current midwives training compliance being 83.% and 88.8% for obstetricians.

At the Whiston site improvements have been made in terms of documentation for risk assessment, use of aspirin and vitamin D which has improved the compliance rate alongside the implementation of electronic blood pressure monitors for use by all community midwives.

Element 3: Raising Awareness of Reduced Fetal Movements
Both maternity sites are 100% compliant including ongoing audits. Harmonisation of policies and implementation of the guidance continues to ensure sustained improvement.

Element 4: Effective Fetal Monitoring in Labour
Whiston demonstrate sustained compliance at 100% and Ormskirk has reduced compliance to 80% from 100%. The audit sample size at Ormskirk was required to be increased to meet the LMNS requirement which resulted in the audits being discounted for this review.

The quality improvement programme, with delivery suite co-ordinators reviewing documentation and ensuring completion of required countersigning and reminding staff at ward rounds and during fresh eyes reviews, to ensure all risk and CTG assessment stickers are completed fully has been successful in improving the compliance to the audit standard.

Element 5: Reducing Preterm Birth
There has been a reduction in compliance for both sites services to 81%. There are 8 process indicators and 4 outcome indicators within this element of SBL with data submitted as part of the Maternity and Neonatal collaborative. The maternity and neonatal service are working together to ensure improved compliance with data quality and documentation. A new admission document has been introduced on the neonatal unit to support documentation of information required for Mat Neo data collection.

The maternity service is fully compliant with the requirement to have key roles in post including an obstetric consultant, a neonatal consultant, a midwife, and a neonatal nursing lead for preterm birth. Following a successful recruitment process, fixed term preterm birth midwives on both sites commenced in post in November 2023 making the teams fully compliant. Ormskirk are required to provide evidence of Neonatal roles in the next submission to meet the LMNS requirement.

A detailed action plan has been implemented which focuses on improvement of preterm audits and NWNODN dashboards, in terms of optimisation for administration of antenatal corticosteroids, magnesium sulphate, intravenous antibiotics in labour and neonatal temperature.

Engagement from the neonatal team regarding documentation of discussions held with parents prior to a potential preterm birth has been undertaken to support improving compliance.

On both sites a significant improvement has occurred to improve provision of early breastmilk. This has included patient focused posters to promote expressed breast milk on the Neonatal unit, staff education to support women and ensuring documentation of discussions which has been facilitated by preterm birth leads and infant feeding team.

Element 6: Management of pre-existing diabetes
Both services remain 100% compliant including ongoing audits.

2.7. Care Quality Commission CQC Review

The maternity service received the final CQC report on 5th April following its inspection on 7th and 8th December 2023.

The report rated the services as:
- Whiston: Good overall and good for being safe and well-led
- Ormskirk: Good overall and for being well-led. It was rated requires improvement for being safe.

Whiston areas for improvement
Three areas were identified as **should** actions for improvement which were,
- Ensure a vision and strategy is developed for the service that incorporates recommendations from the Ockenden report.
- Continue to monitor and take action to ensure baby observations are completed in line with national and trust guidance.
- Ensure staff discarding or witnessing epidural infusions sign the controlled drug register and record the actual amount administered.

Ormskirk areas for improvement
Three **MUST** do actions were identified to comply with its legal obligations which were:
- Ensure all staff are up to date with mandatory training including but not limited to pool evacuation.
- Ensure staff accurately complete and document modified early obstetric warning scores and newborn risk assessments, record CTG assessments and fresh eyes in order to identify and escalate women, birthing people and babies at risk of deterioration.
- Ensure there are sufficient numbers of staff deployed to keep women, birthing people and babies safe.

Actions the service **should** take to improve were:
- Ensure that records are maintained for all discarded medicine used for epidurals.
- Ensure all staff receive supervision and annual appraisals.
- Consider making electronic records accessible to women and birthing people.
- Ensure incidents are reviewed in a timely manner.

- The service should develop a maternity-specific strategy and vision.

Progress in delivering the maternity action plan

Compliance for maternity specific safety training inclusive of PROMPT, pool evacuation, fetal surveillance and neonatal life support exceeds 98% for all required staff groups, although the division acknowledges that there remains work to do in relation to ensure sustained compliance for Core and Compulsory training within the Women and Children's division which were 83.9% for Core and 84.1% for Compulsory at the end of Q3. Compliance is monitored via weekly matrons' operational group to ensure focus remains on sustained improvements.

Current audit data demonstrates an overall trend of improvement to compliance for MEOWS, NEWS, fresh eyes and epidural wastage, with the findings and targeted improvement actions discussed and devised locally with relevant stakeholders through local risk and governance meetings, with oversight from the divisional leadership teams.

In relation to ensuring enough staff are available, following the recruitment of a cohort of 21 newly qualified midwives in October on receipt of their NMC registration to undertake midwifery preceptorship there were minimal vacancies within the service. A robust rolling recruitment programme is in place to ensure timely recruitment into vacancies if they arise during the year. There is an open evening planned for Spring 2025 to showcase opportunities for new registrants at MWL. Further detail regarding the current staffing position is captured in section 3 of this paper. There is a maternity bleepholder who has oversight f the maternity service on each site alongside acuity and activity. This enables appropriate redeployment of staff as required. The Ormskirk site has adopted the documentation used by the maternity bleepholder on the Whiston site which captures data every 4 hours with documentation of any redeployed staff and the rationale.

The development of a specific Maternity Strategy remains outstanding with ongoing work to be undertaken in Q4 with an aim for launch in the new financial year, twelve months after the inception of the Women and Children's Division.

There is work in progress in relation to the action to consider making electronic records accessible to women and birthing people. Following the deferment of the procurement process for a Trust and maternity EPR system, there is ongoing work in relation to the implementation of a Maternity EPR across MWL.

The Maternity Improvement Plan is updated with continued testing and presentation of evidence at the directorate and divisional governance meetings and was presented to Quality committee on 18th February 2025.

The CQC are refining their assessment and will use a single assessment framework. The five domains of safe, effective, caring, responsive and well led will remain. However, the key lines of enquiry will be replaced by a series of quality statements and will use **six evidence categories** to help them understand the quality of care being delivered for each quality statement which includes:

- People's experience of health and care services
- Feedback from staff and leaders
- Feedback from partners – people representing organisations that interact with the service or organisation that is being assessed.
- Observation by CQC inspectors, specialist professional advisors and Healthwatch

- Processes (including incidents, waiting times, audits, policies and procedures)
- Outcomes focusing on the impact of care processes on individuals, with data taken from patient level data sets and national clinical audits.

Preparedness for CQC inspections continues across the service with each service completing a self-assessment in relation to the quality standards and collating supporting evidence. Regular updates are in progress with monitoring at the Divisional Governance meeting.

2.8. Safety Champions

Safety champions are within MIS safety action 7.

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

Schedules for Safety Champion Walkarounds for both sites for 2025 are in place in order to meet frontline clinical and non-clinical staff alongside women and their families to enable to an additional opportunity for any safety concerns to be raised which are feedback at the Maternity safety champions meetings. The feedback proforma has been modified to identify if any safety actions are identified where they are escalated too.

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

The Maternity Safety Champions review the PQSM tool monthly and reported to Board. The tool is presented to the Committee and attached as Appendix 1.

Both sites have Maternity, Neonatal Voice Partnership (MNVP) leads in post with feedback into the safety champions meetings. Within Q3 additional monies were confirmed by the LMNS to support the expansion of activities undertaken by the MNVP which includes engagement with service users across the MWL locality footprint and will provide an increase in capacity to ensure attendance at Intrapartum forums and local governance meetings.

15 steps Maternity and Neonatal events were undertaken in 2024 which are reviews of maternity and neonatal services from a service user perspective led by the MNVP lead. The review looked at 4 key themes: welcoming and informative, friendly, and personal, safe and clean and organised and calm.

The reports have previously been presented to the Quality Committee in 2024 and action plans to address the findings have been developed

Ormskirk site: All actions completed which include:

- Perspex removed from clinic reception desk.
- Provision of drinking water and juice available in outpatient areas with bottled water available in vending machines.
- Patient information boards updated.
- Repairs/maintenance work completed that was identified during the visit.

- Breast feeding information available in various languages.
- MNVP information updated.
- Improved information for partners on neonatal unit (e.g., Dad Pad Neonatal)

Whiston Site: Completed actions include the following and continued work on some further actions

- Increased multilingual resources on notice boards within the neonatal unit.
- Review of leaflets and resources to ensure inclusivity undertaken and to be considered for any future resources.
- Signs regarding tailgating moved to a more visible location on the Neonatal external doors
- Mental Health support leaflets reviewed on Trust website to ensure they are inclusive to all family types completed.
- Signposting of infant changing facilities included in information provided to women.

2.9. Complaints and Claims

Maternity:

There were 6 formal complaints received in Q3 for the Ormskirk Site. 5 were closed and resolved within the required time frames. 1 complaint remains open and has been delayed due to mitigating factors however this response is now currently in draft. The complainant has been informed of the delay.

There was 1 complaint received at the end of Q2 for Whiston that was completed and closed in Q3 within the 60-day timeframe.

There have been 4 formal maternity complaints received in Q3 for Whiston site. This included a 2nd stage complaint following a response sent to the patient in Q1 which subsequently led to further questions regarding care and treatment. This remains an open complaint with the response delayed due to the unavailability of a staff member named in the complaint who was required to provide a response. The complainant was informed of the delay, and the investigating officer has now completed the draft. A further complaint was closed as resolved within time frame and the remaining 2 are on track to be answered within the expected timeframes in Q4.

	October 2024		November 2024		December 2024		**Total**	
Site	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	**Ormskirk**	**Whiston**
Number of Complaints	2	2	4	1	0	1	**6**	**4**

Actions from Closed Complaints

- Patient experience themed quality bus round with anonymised feedback from complaints highlighted to share with staff.
- Shared learning distributed, reminding staff of the correct process for following up test results.
- Parent Education offer and information resources regarding caesarean section and induction of labour to be reviewed.
- Audit of daily medicine ward rounds to commence.

Neonatal:

	October 2024		November 2024		December 2024		**Total**	
Site	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	**Ormskirk**	**Whiston**
Number of Complaints	0	1	0	0	0	0	**0**	**1**

No complaints were received in Q2 for the neonatal services and therefore there was no learning or actions for this period. There were no complaints in Q3 for neonatal services at Ormskirk but there was 1 complaint for the Whiston site which related to care and treatment in 2016. The response is in progress and will be completed in Q4.

Claims

There have been no new claims received at Ormskirk for Maternity services and no claims for both neonatal services in Q3.

The maternity service at Whiston received 1 claim in Q3 which related to the maternal death that occurred in December 2023.

The claims scorecard is only produced annually in September, and it now contains the data for all MWL sites for the years 2014/15 until the end of 2023/24.

The details for the combined scorecard are:

The Top 5 injuries by volume for obstetrics:

- Psychiatric/psychological damage
- Stillborn
- Fatality
- Unnecessary Pain
- Additional/unnecessary Operation(s)

The Top 5 Causes by volume within the scorecard were:

- Failure or delay in treatment
- Failure/delay diagnosis
- Fail to monitor first stage of labour.
- Fail to monitor second stage of labour.
- Failure to make a response to abnormal fetal heart rate.

Themes of complaints in Q3 related to communication, staff attitude and information sharing and were not associated with the top 5 causes within the claim's scorecard.

2.10. Maternity Red Flags

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

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

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

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

Theme	Total for Q3 2024/25							
	Oct 2024		Nov 2024		Dec 2024		Total	
	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk
Delayed or cancelled time critical activity	0	1	0	0	0	0	**0**	**1**
Missed or delayed care	0	0	0	1	0	0	**0**	**1**
Missed medication	0	0	0	1	0	0	**0**	**1**
Delay of more than 30 mins in pain relief	0	0	0	0	0	0	**0**	**0**
Delay of 15 minutes or more between presentation and triage	10	1	12	0	4	0	**26**	**1**
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	**0**	**0**
Delay of 2 hours or more between admission for induction	0	1	0	1	0	1	**0**	**3**
Delay in transfer to delivery suite for ARM	0	1	0	0	0	1	**0**	**2**
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	**0**	**0**
Any occasion when 1 Midwife is not able to provide continuous 121 care in labour	0	0	0	0	0	0	**0**	**0**
If Delivery Suite Coordinator was not supernumerary and the reason why?	0	0	0	0	0	0	**0**	**0**
TOTAL	**10**	**4**	**12**	**3**	**4**	**2**	**26**	**9**

All 26 of the Midwifery Red Flags on the Whiston site reported in Q3 related to delays in triaging women on their attendance at Maternity Triage of >15mins. All incidents have been reviewed by the clinical lead and matron to identify themes and trends. There were no additional incidents related to these delays in undertaking triage and no harm has occurred

Responsive reporting of all Midwifery Red Flags within Triage is now occurring following training in September with additional work around how to address and seek clinical support when simultaneous attendances occur. Initially this saw an increase in red flags likely to have represented an improved reporting culture, but this has now reduced as systems and processes regarding escalation have now been embedded within the department. The triage department is consistently achieving over 98% compliance to the target of triage within 15 minutes of arrival.
The new telephone system has had a positive impact in ensuring all calls are answered with appropriate support and action taken at times, however an emerging theme of high volume of calls alongside triage breaches has been highlighted in the analysis and is being monitored by the department leads.

At Ormskirk there were 9 midwifery red flags reported during Q3, these were evenly spread across the period with no theme of days or times noted. The 3 red flags for delay in commencing induction of labour were due to the number of ongoing inductions at the time who remained on the maternity ward. The 2 red flags relating to delay in transfer to Delivery suite for ARM were due to acuity on Delivery suite. There were no harms reported for any of these incidents.

The role of the Delivery Suite Shift Coordinator is a key role in the intrapartum area, and they are present 24/7 which is a recommendation within the Ockenden Report. The Delivery Suite Coordinator is supernumerary which is a pivotal role to enable them to undertake their role effectively in providing an overarching view, effective leadership, clinical expertise and facilitating communication between professionals whilst overseeing appropriate use of resources. No red flags have been reported in this reporting period due to compliance. A monthly audit is also undertaken which has confirmed 100% compliance to the shift coordinator being supernumerary and is presented at the Maternity Governance meeting. The maternity bleepholder documentation has a section to confirm at the minimum 4 hourly walkabouts that the shift leader is supernummary and in the event that this was not achieved a narrative and rationale as to the reason for noncompliance.

Midwifery red flags are all Datix incidents, and any learning is disseminated via ward meetings, safety huddles and the Maternity Governance & Quality meetings.

3. Workforce

Maternity workforce is a requirement of MIS safety action 5 and the neonatal staffing relates to MIS safety action 4.

The Women's and Children's division was formally established in April 2024 with a dedicated divisional structure of a triumvirate consisting of a Divisional Director of Operations, Divisional Director of Midwifery and a Divisional Medical Director. The Division consists of maternity, gynaecology services, paediatric and neonatal services on two sites.

Across the two legacy sites there is a difference in the % uplift used to determine the required staffing levels. The Division will be undertaking a staffing review to identify the required uplift incorporating sickness, annual leave, training, and maternity leave. Once completed this review findings will be to present to the executive team to enable standardisation across the maternity service and detailed within the maternity update paper to quality committee.

Ormskirk Maternity Staffing

The number of births recorded at MWL (Ormskirk site) between October and December 2024 was 502, which is a decrease of (9.7%) 54 births compared to the previous 3 months (Q2 2024/25) and a decrease of 1 birth compared to the same reporting period in 2023/24.

There were 633 bookings in quarter 3 which is an increase of 44 bookings (7.5%) compared with quarter 2 2024/25. Comparing the quarter 3 bookings with quarter 3 in 2023/24 there has been a 10.5% increase (60 bookings). The data demonstrates that there are fluctuations in bookings and births by up to 10%.

The January 2022 BR+ report identified that the Delivery Suite case mix for 2021 indicated that 58.2% of women were in the 2 higher categories IV and V which was in keeping with the average for England of 58%. This was an increase of 7% compared with the 2018 report of 51%, which reflected the increase of induction rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions.

The recommendation for the funded establishment for the provision of direct midwifery care in BR+ included a 25% uplift for annual leave, sickness, and study leave was 117.40wte. Following the recommendations in the Ockendon report the clinical midwife uplift was amended to 30%.

The overall funded establishment is 128.01WTE and includes 5.28wte Band 3 MSWs who are based on the maternity ward and providing clinical care in line with the recommendations of the Birthrate plus report.

The midwifery establishment is divided into direct clinical care and non-direct clinical care.

The reporting timeframe of July-December 2024 identifies that BR+ recommended 107.89 WTE for the provision of direct maternity care. The funded establishment is above this figure at 110.79WTE which includes 5.28WTE maternity support workers.

The recommendation is for there to be 9.51 WTE staff for non-direct clinical roles which was based on 9% of the total clinical time. The current funded establishment is 17.22wte and is above the recommended staffing. The additional staff include the provision of cover for elective caesarean section lists, increased training because of Ockenden and 3.37 WTE externally funded posts which include 0.4WTE bereavement midwife, 1WTE preceptorship/ workforce midwife, 0.11WTE perinatal trauma midwife, 0.4WTE pre-term birth/ multiple pregnancy midwife and 0.6wte for MSW retention. There is also 1WTE band 7 digital midwife secondment in place to support the implementation of the new electronic maternity system. This is funded via the digital transformation monies.

The non direct clinical roles in this report have the maternity managers included compared to the previous report that had them in the direct clinical staffing role.

There is currently a vacancy for 1 WTE 8a community/ outpatient matron due to a retirement with the post which has not been successful in recruitment. A review of the remit of this role has been undertaken and a decision has been agreed to readvertise this role as an antenatal matron who will cover antenatal services and antenatal screening services across MWL with the current community matron becoming the matron for community across MWL.

The Antenatal and Newborn Screening team are now fully established with a named specialist screening midwife, a deputy and failsafe officer in post.

2WTE band 5 midwives are due to commence in post in February 2025 along with a 0.4wte band 7 pelvic health specialist midwife. There are vacancies of 5.1WTE midwifery posts and recruitment is ongoing.

3.2WTE band 2 Maternity care assistants are undergoing employment checks and a further 1.6WTE have a start date arranged for January 2025.

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

Date	Midwife to Birth ratio
October 24	1:22
November 24	1:22
December 24	1:22

There has been 100% compliance noted for the provision of 1-1 care in labour and the availability of a supernumerary Delivery suite shift coordinator for this 3-month reporting period.

The Ormskirk biannual staffing paper July- Sept 2024 is included in Appendix 2.

Whiston Maternity Service:

The number of births at MWL (Whiston site) between October and December was 873 which was a decrease of 54 (5.8%) compared to the previous quarter, and an 8.2% decrease compared to the same reporting period in 2023.

There was a slight increase of 13 bookings (1.3%) compared to Q2, with an overall 1% increase compared to the same reporting period in 2023.

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

The BR+ report is inclusive of a 22% uplift for annual leave, sickness and study leave and identified that 14.49 WTE is the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical WTE. The funded establishment is 14.39 WTE and aligns to the recommendations and therefore no variance is noted. In addition, the non-direct care band 7 posts include three fixed term externally funded posts (2.2WTE) which are included in the contracted figures but not in the funded establishment and a business case will be required as the expectation is that these posts will be substantive once the external funding ceases.

The BR+ report identified that the required WTE for the provision of direct maternity care was 160.98 WTE and the current funded establishment is 168.22 WTE. Agreement to substantively over establish by 6 WTE to cover maternity leave is maintained and the service is therefore in line with the recommendations of the BR+.

At the end of Q3 the service had zero actual midwifery vacancies, and a 2.25WTE MSW vacancy, with further interviews scheduled in January 2025 to recruit to the existing and projected gaps due to reduction in hours, retirements, and leavers currently working notice period. Our ongoing rolling recruitment programme continues to ensure any deficits are advertised as early as possible and that a proactive approach is adopted to fulfil vacancies that arise.

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

Date	Midwife to Birth ratio
October 24	1: 24
November 24	1: 27
December 24	1: 26

The LMNS have been asked to support in looking at a review across C&M to ensure that the calculation of the midwife to birth ratio is standardised and consistent for all providers, specifically relating to non-direct care giving staff, DS shift coordinators and ward managers and if they are included or excluded in the calculation. MWL currently use the formula and methodology suggested by BirthRate Plus to produce the calculation.

There has been 100% compliance noted for the provision of 1-1 care in labour and the availability of a supernumerary Delivery suite shift coordinator for this 3-month reporting period.

The Whiston biannual staffing paper July- Sept 2024 is included in Appendix 3.

The maternity service will be required to consider a further BR+ workforce review in 2025/26 as in 2025 it is 3 years since the previous review. MIS year 6 requirements were that a systematic, evidence-based process to calculate midwifery staffing establishment must have been completed within the last three years for which the service was compliant but if this requirement remains in year 7, a further assessment will be required.

Neonatal workforce

Neonatal staffing relates to SA 4 of MIS.

The Division is currently preparing a paper for the Executive team in relation to a proposed cot reconfiguration across MWL. There is currently a transformation programme in existence in Cheshire & Merseyside with a renewed focus and pace to implement changes to the current commissioned capacity within 2025, however timescales remain unclear from the Neonatal Operational Delivery Network (ODN). The paper will summarise the current and potential cot reconfiguration based on data from the Neonatal Operational Delivery Network (ODN) intelligence and the Division will outline the associated workforce required.

Both Neonatal units currently meet the BAPM Neonatal Nursing Standards in MIS Year 6 utilising the Neonatal workforce calculators for each site which was undertaken in 2024 and shared with the ODN based on the current cot configuration.

Neonatal services

Both neonatal services are currently funded for nurses in accordance with BAPM requirements for the commissioned cot profiles. Transitional care is in place at Ormskirk and there are plans for Whiston to commence by the end of Q4.

Cots profiles are under review both internally and externally based on actual activity and acuity of babies. A paper is going to Executive Committee in March 2025 with options to consider for MWL.

Qualified in Speciality (QIS) trained staff across MWL

There is a mandatory requirement to ensure 70% of the neonatal workforce are Qualified in Specialty (QIS). There is a programme in place to support staff to achieve this qualification. The pathway to achieve QIS requires initial completion of the Foundation in Neonates (FIN) course followed by a QIS course both of which require a period of secondment to a Level 3 unit for 4-6 weeks for each course (longer for part time staff). In view of this requirement the release of staff is on an individual basis to ensure the provision of a safe service.

There is a national shortage of QIS nurses and therefore we are required to develop our own staff, it is essential our workforce is optimum in order to support the nurses whilst undertaking the programme.

There are plans in place to achieve full compliance of QIS nurses for both sites.

FiCare Accreditation

Ormskirk currently stage 1 Green. Reassessment for Stage 1 passed in July 2024. Stage 2 Assessment due early 2025.

Achieved at Whiston December 2023. FiCare sustainability visit completed January 2025 and reassurance was provided that FiCare remains embedded on the unit. Working towards FiCare 2 accreditation.

UNICEF accreditation

The Ormskirk Neonatal unit is currently preparing for its Stage 2 BFI accreditation in February 2025.

Whiston neonatal service do not have a date for accreditation but are working towards the required standards.

3.1. Sickness

Sickness	October 24	November 24	December 24
Ormskirk Maternity	5.85%	6.83%	5.48%
Whiston Maternity	6.59%	8.80%	8.99%
Ormskirk Neonatal	4.56%	10.07%	16.79%
Whiston Neonatal	13.37%	18.37%	11.78%

The sickness within the Neonatal service on the Ormskirk site had increased in November and December. The main causes of sickness related to short term sickness of cold, respiratory and gastrointestinal issues.

Sickness continues to be managed according to the MWL policy, with monthly oversight and support from Human Resources and support to staff including health and wellbeing support as required.

3.2. Continuity of Carer (CoC)

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

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

The current Whiston CoC position and expansion is currently on hold which has previously been agreed at Executive level. A revised plan for the delivery of a Maternity Continuity of Carer model in line with delivering 'Maternity Continuity of Carer Model at Full-Scale' guidance which identified that a whole new model of care is required utilising a mixed risk model providing enhanced midwifery care to women and babies of Black, Asian and mixed ethnicity and those living in the 10% decile of deprivation. Further review of this model is required alongside a review of required staffing to support this revised model of care once the current funded establishment is achieved with appropriate skill mix to enable to model to be achieved.

3.3. Maternity Suspension of Services

For the reporting period of October to December 2024 there were no suspensions of maternity services on the Whiston or Ormskirk sites.

3.4. Neonatal Unit Closures

There were 22 closures of the Neonatal units which were all on the Whiston site which were reported to the NW ODN during the reporting period. Throughout the periods of closures for external babies including repatriation of babies, the unit remained open to emergency admissions with plans to stabilise and transfer any babies that required admission.

During periods of external closures, close liaison is maintained with the maternity service as there is a requirement to risk assess for the risk of pre term birth or for any babies likely to require admission to the neonatal unit to determine if an inutero transfer is required.

Ormskirk site			Whiston site	
Q3 24/25	**No of closures**		**Q3 24/25**	**No of closures**
October 24	0		October 24	17
November 24	0		November 24	5
December 24	0		December 24	0
Total closures	**0**		**Total closures**	**22**

3.5. One to One Care in Labour

Maternity Services aim to achieve 100% of one-to-one care to women in established labour and this is monitored and reported within the safe staffing report and the monthly dashboard. For the Q3 period there have not been any occasions when one to one care in labour was not provided.

4. Patient experience

Q3 Friends and Family Feedback (Positive %, Very Good/Good Response)

Ormskirk:

Area	October 24	November 24	December 24	Trust Target
Antenatal	75%	100%	66.7%	95%
Birth/Delivery	94.7%	100%	98%	93%
Maternity Ward	91.7%	100%	84%	92%
Postnatal Community	No Score	100%	100%	91%

Whiston:

Area	October 24	November-24	December 24	Trust Target
Antenatal	100%	97.4%	96.7%	95%
Birth/Delivery	96.1%	75%	97.3%	93%
Maternity Ward	100%	85%	100%	92%
Postnatal Community	100%	100%	100%	91%

Qualitative feedback was reviewed, relating to all areas. No themes were identified, and any feedback received was shared with the multidisciplinary maternity team via monthly

newsletters, including when individual staff members had been highlighted for providing excellence.

Response rates for friends and family test fluctuate for the service. The qualitative narrative suggests that although there are four touch points in Maternity, women and families often provide an overarching response of experience of maternity care as one submission.

The maternity service has developed an action plan in response to the National CQC maternity survey which has been presented to the Patient Experience Council and Quality Committee in February 2025. The maternity service will review their local survey documentation based on the questions and findings of the recent survey which will be utilised to obtain feedback which will be added to the working action plan. Support from our MNVP leads and Corporate Quality team will be utilised to liaise with women and their families.

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

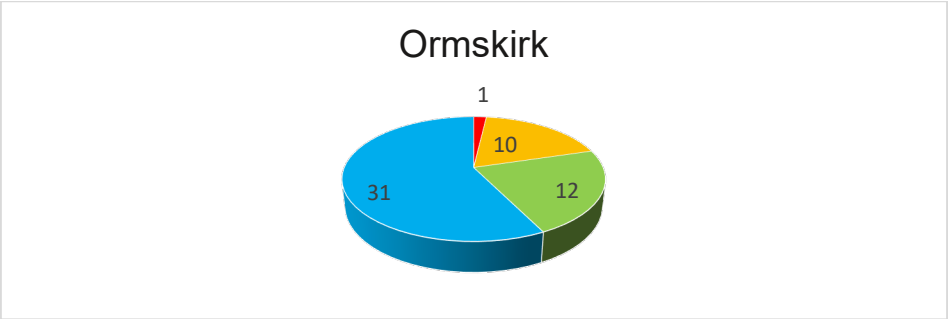
While most women have a positive experience of NHS maternity and neonatal services in England, independent reports show that some families have experienced unacceptable care, trauma, and loss. The publication of NHSE: Three-Year Delivery Plan for Maternity and Neonatal Services in March 2023, brought together learning and actions from national reports including the Ockenden final report into one document, ensuring accountability at every level of the system encouraging the effective spread of best practice in maternity and neonatal care, and support the implementation of a cross-system approach to improving care for services users.

NHS England Regional Maternity Team have developed a process via a Maternity Provider Oversight Panel (MPOP) to review ongoing actions and progress towards the deliverables set out in the NHSE Three-Year Delivery Plan for Maternity and Neonatal Services, with assurance of implementation and ongoing monitoring and evaluation sought from quarterly provider submissions of evidence via the LMNS, with an additional annual provider visit scheduled for each site. Quarterly LMNS assurance meetings commenced in 2024 to review evidence and monitor progress.

On the 18th November representatives from the LMNS Senior Leadership Team and representatives from the ICB Place conducted an MWL provider visit to the Whiston site, with an additional site visit undertaken at Ormskirk on 4th December 2024. Positive feedback has been received with some areas of challenge that the LMNS has committed to supporting the service.

Currently we are in Year 2 of Maternity and Neonatal Services Three Year Delivery Plan. The LMNS have validated the evidence for the Q2 submission and highlight the continued progress of MWL actions. Currently there is 1 action which relates to MCoC and further roll out. Following discussion with LMNS funding has been secured to support enhancing MCoC teams to deliver a targeted offer for most vulnerable women to reduce health inequalities.

The current BRAG status of all actions is highlighted in the charts below following the LMNS validation of Q2 submission.



Q3 evidence submission will be made in February 2025 to the LMNS for review and validation.

6. Recommendations

The Trust Board are asked to note the report.

7. Appendix

- Appendix 1: PQSM
- Appendix 2: Ormskirk Maternity staffing report: July- December 2024
- Appendix 3: Whiston Maternity staffing report: July- December 2024

APPENDIX 1

Mersey and West Lancashire Teaching Hospitals NHS Trust					
Maternity CQC Maternity Ratings - Whiston Hospital	**Safe**	**Effective**	**Caring**	**Well-Led**	**Responsive**
	Good	Good	Good	Good	Good
Maternity CQC Maternity Ratings - Ormskirk Hospital	**Safe**	**Effective**	**Caring**	**Well-Led**	**Responsive**
	Requires Improvement	Good	Good	Good	Good

	Dec-24			Nov-24			Oct-24			Sep-24			Aug-24			Jul-24			Jun-24			May-24			Apr-24			Mar-24			Feb-24			Jan-24		
	Whiston	**Ormskirk**	**Total**	**Whiston**	**Ormskirk**	**Total**	**Whiston**	**Ormskirk**	**Total**	**Whiston**	**Ormskirk**	**Total**	**Whiston**	**Ormskirk**	**Total**	**Whiston**	**Ormskirk**	**Total**	**Whiston**	**Ormskirk**	**Total**	**Whiston**	**Ormskirk**	**Total**	**Whiston**	**Ormskirk**	**Total**	**Whiston**	**Ormskirk**	**Total**	**Whiston**	**Ormskirk**	**Total**	**Whiston**	**Ormskirk**	**Total**
The Number of Incidents Reported Graded as Moderate or Above	1	0	1	1	0	1	1	0	1	0	0	0	0	0	0	0	2	2	0	1	1	0	1	1	0	2	2	0	0	0	1	0	1	0	1	1
Healthcare Safety Investigation Branch / Maternity and Newborn Safety Investigations (HSIB/MNSI) / NHS Resolution (NHSR) / CQC or Other Organisation with a Concern or Request for Action Made Directly with Trust	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Coroner Reg 28 Made Directly to Trust	0	0		0	0	0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Term Admission to NICU from DS	5	7	12	6	4	10	7	4	11	9	1	10	17	4	21	10	4	14	8	9	17	13	2	15	22	5	27	15	5	20	14	4	18	23	8	31
Number of StEIS Reportable Incidents / HSIB/MNSI Cases	1	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0
Number of Cases Reported to HSIB/MNSI	1	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0
PMRT	1	1	2	1	0	1	1	2	3	0	0	0	0	0	0	3	0	3	0	1	1	0	1	1	0	0	0	0	0	0	1	1	2	0	0	0
Number of Intrapartum Stillbirths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of Neonatal Deaths before 28 days at MWL	0	1	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0	0	0	1	0	1	1	0	1	0	0	0
Number of Neonatal Deaths before 28 days Elsewhere	0	0	0	1	0	1	0	1*	1	0	0	0	1	0	1	1	0	1	1	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0
No Babies Born with HIE Grade 2 +3	*	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0
Number of Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1:1 Care in Labour	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Supernumerary Shift Co-ordinator	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Consultant Delivery Suite Cover (Hrs)	98**	74.5**	N/A	98	74.5	N/A	98	74.5	N/A	98	74.5	N/A	98	74.5	N/A	98	74.5	N/A	98	74.5	N/A	98	74.5	N/A	98	74.5	N/A	98	74.4	N/A	98	74.5	N/A	98	74.5	N/A

*** No of Babies Born with HIE Grade 2+3** : pending Case from December 2024 awaiting MRI scan to confirm grade of HIE.

** Data entered is the number of actual Consultant hours cover on DS. Safer childbirth recommends 96 hours for units with bith of 2500-4000 births (Whiston site). There is no specified dedicated hours for units of less than 2500 births (ormskirk)

1 Incident reported Graded as moderate or above in December - A baby that required cooling following labour. This case is also s reportable to MNSI and StEIS. The MRI is still awaited for this case, therefore a final diagnosis and grading of HIE is still awaited, and it has not yet been included as a HIE grade 2 or 3 case this will be updated in the next report.

12 Term transfers to NICU from delivery suite. The majority of reasons for transfer continue to be respiratory 1/12. The other cases included:
1 baby planned admission for social concerns
1 baby for hypoglycaemia (Diabetic mother).
1 baby planned admission due to family history of myathenia gravis
1 baby for suspected sepsis

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

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

APPENDIX 2
Ormskirk Site Maternity staffing report July – Dec 2024

Background

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

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

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

Birth rate at Ormskirk Maternity site

The number of births on the Ormskirk site between the 6-month period, July to December 2024 was 1058 which saw an increase of 22 births compared to the same period in 2023. However, when the 12 months January to December 24 was compared to the 2023 data, this identified as an overall increase in births of 125.

Bookings, comparing quarter 2 & 3 2023 with the same period in 2024 have shown an increase of 16, with an overall difference of 64 in bookings between January to December 2023 and January to December 2024. Ormskirk Maternity Services uses scenario-based forecasts based upon the previous years projected births as per National Recommendations (NICE 2015). The rationale for utilising projected birth rates to plan for midwifery staffing is to estimate the potential resource impact associated with recommendations regarding midwifery staffing ratios and provide a woman in established labour with supportive one-to-one care which is essential for safe midwifery care.

In summary comparing 2023 and 2024 births for July to December there has been an increase of 2.11%, comparing bookings for the same time period there has been an increase of 1.34% Expanding the data to compare calendar year 2023 with 2024 identified an increase in births of 5.9% and an increase in bookings of 2.7%

Births

Month	July	Aug	Sept	Oct	Nov	Dec	Total
Q2-Q3 2024 Births	195	170	191	186	139	177	1058
Q2-Q3 2023 Births	180	180	173	171	158	174	1036
Difference per month	+15	-10	+18	+15	-19	+3	+22

Month	Jan	Feb	March	April	May	June	Total
Q4 2023 and Q1 2024 Birth	174	191	189	176	182	161	1073
Q4 2022 and Q1 2023 Births	169	154	157	168	153	169	970
Difference per month	+5	+37	+32	+8	+29	-8	+103

Bookings

Month	July	Aug	Sept	Oct	Nov	Dec	Total
Q2-Q3 2024 Bookings	199	197	193	221	232	180	1222
Q2-Q3 2023 Bookings	227	206	200	204	178	191	1206
Difference per month	-28	-9	-7	+17	+54	-11	+16

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

Birthrate Plus® + Staffing

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

The Maternity funded establishment for the provision of direct midwifery care at the time of this staffing report is above the recommendations of the 2022 Birthrate plus assessment. Following publication of the report and a serious incident within the Maternity service the Trust Board agreed to increase the funded establishment by 5.55 WTE to provide separate cover for elective caesarean section lists, increased training as a result of Ockenden and a number of externally funded posts. A staffing review in 2023 also resulted in increasing the funded establishment for direct midwifery care to include an average uplift representative of the last 3 years annual leave, sickness, training, and maternity leave as per Ockenden essential safety action one.

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

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

Direct Care

Midwives	Funded establishment	Contracted	Difference
Band 7	12.54	16.93	- 4.39
Band 5/6	92.97	83.48	9.49
Band 3 MSW	5.28	5.28	0
Total	110.79	105.69	5.1WTE vacancy

Non direct clinical care

Senior management and specialist midwives	Funded establishment	Contracted	Difference
8 and above	4.00	2.9	1.1
Band 7	12.52	12.12	0.4
Band 6	0.7	0	0.7
Total currently	17.22	15.02	2.2 vacancy

The above band 7 posts include externally funded posts which are a 0.4wte additional hours for the bereavement midwife, 1wte preceptorship/ workforce midwife, 0.11wte perinatal trauma midwife, 0.4wte pre-term birth and multiple pregnancy midwife, 0.4wte pelvic health midwife, 1wte digital midwife (funded by Digital transformation team for 12 months from 1st July 2024).
In addition, there is 0.7wte externally funded band 6 hours for MSW retention. This equates to 3.37 WTE externally funded posts.

The Antenatal and Newborn screening team at Ormskirk is now fully established including, Screening Midwife, Deputy screening midwife and Failsafe Officer

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

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

Each individual service will have their case mix identified using 5 different categories (Cat 1- V) with the lower the score the more normal the processes are for labour and birth and the higher scores indicating when a mother and/or baby require a very high degree of support or intervention. Together with the case mix, the number of midwife hours per

patient/client category plus extra midwife time needed for the complicated categories of III, IV & V and calculates the clinical staffing for the annual number of women delivered. Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

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

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

The BR+ report identified that 9.51wte is recommended as the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical whole time equivalent (wte).

The funded establishment for non-direct care staff is 17.22 with a contracted establishment is 15.02WTE with 2.2WTE due to vacancies. 3.37 WTE are externally funded midwifery posts and the inclusion of 4WTE ward managers who have been included in the non-direct clinical care as they have 100% managerial time but their roles include holding the maternity and site bleep. The non direct clinical care staffing is not at deviance to the BR+ recommendations.

The BR+ report concluded that the required whole time equivalent for the provision of direct maternity care was 107.89wte with a recommended ratio split between midwives and maternity support workers working on the postnatal ward.
The funded clinical midwife establishment at the current time is 110.79wte which includes 5.28wte band 3 MSWs who are based on Maternity ward and who support midwives in line with the recommendation of the 2022 Birthrate plus report. This gives a total of 110.79wte for the provision of direct clinical care, which is above the birthrate plus recommendation. However, this includes the 30% uplift, designated staff for elective caesarean lists and some externally funded posts.

A staffing position at the end of December 2024 identified that the unit was not in deficit to the BR+ funded establishment recommendations for the maternity workforce based on our current modelling ratio of midwife to MSW.
The current vacancy 5.1wte across direct care midwifery posts, with 2wte band 5 due to commence in January 2025. Continued rolling recruitment of midwifery posts to minimise gaps as quickly as possible.
The BR+ report highlights the required additional support for Band 2 support workers whose roles are essential to the service but are not included in the midwifery ratio calculations, the requirement for these support staff to be decided by professional judgement. Recruitment for these is in process with applicants identified for all posts and the first two commencing with the Trust in January.

The report analysed data and acuity for the current model of care provided within SOHT, whilst staffing for BSOTS was included it did not reflect any other future plans or continuity of carer caseload teams. To progress MCoC the maternity service would need to utilise the National Continuity of workforce tool to determine the required additional number of midwives needed to deliver MCoC at full scale as progress is made through the revised MCoC action plan. The findings will be shared with the Committee and Trust Board

following completion, with a view to moving forward once midwifery staffing is in place with an adequate uplift to cover all absences.

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

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

The Maternity Inpatient Matron and Preceptorship Midwife have revised the pathway for band 5 midwives to support an earlier transition to band 6 for those that are ready at around 12 months. early career midwives are now rotating 3 monthly to aid expediated experience across the service.

Our first International Recruited (IR) midwife commenced within the Trust in March 2023 with a 2nd international midwife who joined in January 24. The IR midwives' have required an enhanced level of support and bespoke training plans in addition to the standard orientation and induction plan. However, our 1st International Midwife has now completed her preceptorship and has moved to band 6, with the second progressing well with her preceptorship. The midwives are supported by our preceptorship and pastoral support midwife and all members of the team.

Maternity unit Sickness

	July	Aug	Sept	Oct	Nov	Dec
Sickness	6.21%	6.44%	6.51%	5.85%	6.83%	5.48%

The maternity sickness levels have reduced to 5.48% having been around 6-6.5%% for July- September. Staff shortages have been mitigated by offering extra shifts and bank hours. Uptake of NHSP has been affected by the removal of enhanced rates for NHSP. However, as recruitment has increased the overall midwifery staffing closer to the full establishment figure which, includes an uplift to cover sickness, the need for bank shifts has reduced. Maternity staffing and activity are monitored frequently every day with staff being redeployed to the clinical area of greatest need.

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

A 24/7 maternity bleep holder is available who is a senior midwife of band 7 and above who has oversight of the staffing and clinical activity and oversees any redeployment as required which includes members of the Senior Management Team, Specialist Midwives and utilisation of the escalation process as required. The bleep holder is an additional role 07:30-20:00hrs with the Delivery Suite shift coordinator covering the bleep 19:30-08:00hrs. The Maternity bleep holder documentation is completed 4 times per day and contains documentation of planned versus actual staffing which is completed daily identifying the staffing and activity status. Any redeployment or escalation is recorded on this documentation by the bleep holder. A daily sit rep is submitted at 08:30hrs which is discussed at patient flow meetings within the acute Trust. A daily C+M sit rep is also completed by 11am each day and submitted to the LMNS. This identifies current activity,

escalation undertaken and hot spots with the ability to request a 'Gold' command meeting and formally request or offer mutual aid.

Plans are under review to extend the maternity bleep holder at Ormskirk to a role additional to the shift leader across the 24hours.

Midwife to birth ratio

Month	Ratio
July 24	1:28
Aug 24	1:26
Sept 24	1:27
Oct 24	1:22.42
Nov 24	1:22.2
Dec 24	1:22.5

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

Continuity of Carer

The Trusts current position for Continuity of carer remains on hold due to staffing provision and has been discussed at Board level. The Sapphire Team, our current CoC team was launched in 2017 and has remained fully operational. The Team consists of 7.96 WTE midwives providing antenatal, parent education, hypnobirthing, intrapartum and postnatal care for women living outside the West Lancs area but choosing to deliver at ODGH, there are 4 teams of 2 midwives located at childrens centres, their caseload calculated at 1:36 Working pattern: 9-5 community days and long day/night on Delivery suite to provide intrapartum care for women booked under the care of the team.

Data July to December 2024

METRIC	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24
% of women at 29 weeks on a CoC pathway	8.1%	10.3%	9.1%	8.7%	9.8%	9.8%
% of Asian, Black, or Mixed women at 29 weeks on a CoC pathway	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% of women in bottom decile of deprivation at 29 weeks on a CoC pathway	9.4%	24.0%	15.4%	12.5%	18.2%	24.0%

Age Profile of Midwifery Staffing

The table below indicates the age profile for midwifery staffing with the largest staff group currently being aged 36-40 years of age. Latest data shows that following the recruitment of staff in 2024 there has been a shift across the age range resulting in a more even spread across the ages of 21-60 with a minority of staff now 61 and over.

Age Band	% of Staff
21-25	11.11%
26-30	8.14%
31-35	8.14%
36-40	18.51%
41-45	14.07%
46-50	8.14%
51-55	8.88%
56-60	16.29%
61-65	5.18%
66-70	1.48%

The changes to the NHS pension scheme have led to an increase in midwives over 55 wishing to access their pension fund and remain in work on reduced hours. With the majority of new staff being under 35 this retention has helped to maintain an even spread of age and subsequently experience.

One to One Care in Labour

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

Midwifery Red Flag Events

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

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

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

Theme	Total for Q2 &3 2024/25							
	July 24	Aug 24	sept 24	Oct 24	Nov 24	Dec 24	Total	
Delayed or cancelled time critical activity	0	0	4	**1**	**0**	0		**5**
Missed or delayed care	0	0	0	**0**	**1**	0		**1**
Missed medication	0	0	0	**0**	**1**	0		**1**
Delay of more than 30 mins in pain relief	0	0	0	**0**	**0**	0		**0**
Delay of 15 minutes or more between presentation and triage	2	0	0	1	0	0		**3**
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0		**0**
Delay of 2 hours or more between admission for induction	3	3	9	1	1	1		**18**
Delay in transfer to delivery suite for ARM	0	0	0	1	0	1		**2**
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0		**0**
Any occasion when 1 Midwife is not able to provide continuous 121 care in labour	0	0	0	0	0	0		**0**
If Delivery Suite Coordinator was not supernumerary and the reason why?	0	0	0	0	0	0		**0**
TOTAL	**5**	**3**	**13**	**4**	**3**	**2**		**30**

At Ormskirk there were a total of 30 red flags in total during Q2 & 3, 21 of these were in quarter 1 and 9 in quarter 2, September had the most red flags reported during a period of high activity. Delay in induction was the most common indication for a red flag, and this was due to the number of women requiring induction and the requirement to limit the number of ongoing inductions for safety reasons. The 2 red flags relating to delay in transfer to Delivery suite for ARM were due to acuity on Delivery suite with one woman waiting 15hrs and the 2nd waiting 14hrs. There were no harms reported for any of these incidents.

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

Governance meeting. The maternity bleepholder documentation has a section to confirm at the minimum 4 hourly walkabouts that the shift leader is supernumerary and in the event that this was not achieved a narrative and rationale as to the reason for non-compliance.

The red flags are all Datix reported incidents, and any learning from red flag and Datix incidents are disseminated via ward meetings, safety huddles and the Maternity Governance & Quality meetings.

Summary

Births within Ormskirk Maternity for the period July to December 2024 was 1058 which is a decrease compared to the average of the previous 6 months. However, when compared to the July to December 2023 period there was an increase of 22 births. Bookings for the 6-month period were 1222 which is an increase of 16 bookings compared to the same period in 23/24 and comparable to the previous 6 months.

The Maternity funded establishment at the time of the previous staffing report was in line above the requirements provided by Birthrate including the additional funded roles agreed by the Trust.
The report for July- December 2024 identifies that BR+ recommended that the WTE required for the provision of direct maternity care was 107.89 WTE and a funded establishment above this figure at 110.79WTE which includes 5.28WTE maternity support workers.

BR+ recommends 9.51 WTE for non direct clinical roles and the current funded establishment is 17.22WTe and is above the recommended staffing. The additional staff include the provision of cover for elective caesarean section lists, increased training as a result of Ockenden and 3.37 WTE externally funded posts. The non direct clinical roles in this report have the maternity managers included compared to the previous report that had them in the direct clinical staffing role.
The Maternity Unit is now compliant with Ockenden for the funded establishment including an uplift based on the past 3-year absences at Ormskirk. An updated review of the past 3 years up to April 2024 confirmed that an uplift of 30% was appropriate to maintain compliance with Ockendon.

The vacancy rate is 5.1wte midwives within the direct clinical care roles with 2.0wte midwives in the recruitment process that are anticipated to commence in January 2025. Non direct clinical care vacancies include one maternity matron and a 0.4 pelvic health midwife who is due to commence in post in early 2025.

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

The BR+ report highlights the recommendation of the need for Band 2 Health care workers whose roles are essential to the service but are not included in the midwifery ratio calculations. Recruitment is in process with individuals identified for all the vacant posts.

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

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

Over the past 3 months sickness levels within the maternity service have improved to 5.48% at the end of December 2024 having remained at around 6- 6.5% since July 2024. Staffing is monitored daily the use of NHS professionals bank is utilised to cover deficits. Non direct clinical care midwives are utilised if staffing and acuity indicate insufficient staffing.

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

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

Between July to December 2024 there were 30 Midwifery red flags events. The majority of these were for due delays in commencing induction and for transfer to Delivery Suite for the next stage of induction. Delays of 15 minutes or more between presentation and triage have reduced with only 3 red flags over the 6 months.

There have been no maternity diverts requested during this reporting period.

APPENDIX 3

Maternity Safer Staffing Q2 and Q3 2024/25 (1st July 2024- 31st December 2024)

Purpose:

CNST MIS Safety Action 5 requires submission to Trust Board on a 6 monthly basis of a midwifery staffing oversight report that covers staffing/safety issues (in line with NICE midwifery staffing guidance). For Year 6 scheme this was received by the Quality Committee on 23rd July 2024.

This report provides the continued assurance of safe staffing within MWL Maternity Services between 1st July and 31st December 2024. Included in the report is a breakdown of Birth Rate+ (workforce planning tool for midwifery) and funded establishment for financial year 24/25, demonstrating compliance with outcomes of Birth Rate+ audit received in 2022. Additionally included in the report is the midwife to birth ratio, evidence from the maternity clinical dashboard demonstrating compliance with supernumerary labour ward co-ordinator on duty at the start of every shift and the provision of one-to-one midwifery care in active labour.

Summary:

The report highlights the following for the six-month period 1st July -31st December 2024:

- Births on the Whiston site were 1800, a decrease of 3.3% from the previous six-month reporting period.
- The report details the current versus funded establishment and alignment to BR+ based on a 22% uplift with no variance noted for non-clinical midwifery roles based on 9% of the total clinical WTE.
- BR+ report identified the need for 160.98 WTE direct maternity care staff and the current funded establishment is 168.22 WTE. Agreement to substantively over establish by 6.0 WTE to cover maternity leave is maintained and the service funded establishment is therefore in line with the recommendations of the BR+ assessment.
- Business cases will be required support funding for 2.2 WTE midwives on fixed term externally funded posts and required staffing to deliver MCoC at full scale.
- The service is proactive with ongoing rolling recruitment. At the end of Month 9 there were no actual midwifery vacancies and a vacancy of 2.25WTE MSWs, with further interviews scheduled early in 2025 to recruit to the existing and projected vacancies for these roles.
- There has been a consistent reduction in sickness, however, remains above the Trust target of 4.5%. Sickness and absence management is monitored in accordance with policy supported by HR and HWWB with a current rate of 8.99%.
- 100% compliance noted for the provision of one-to-one care in labour, and the availability of a supernumerary delivery suite shift coordinator for this reporting period.
- 31 Midwifery Red Flag events were reported in the six-month period, all in relation to delays of >15 minutes between presentation and triage as per BSOTS recommendation, with all instances due to high activity in the department. The increase is reflective of an improved reporting culture in the department. There were no additional incidents related to these delays in undertaking triage and no harm occurred.

There were no specific areas of concern to highlight, and Quality Committee are asked to receive and note the information provided in this paper and take assurance for how safe staffing is managed, recruited, and retained to keep women and babies safe within Maternity services.
Corporate objectives met or risks addressed: Care, Safety, Pathways
Financial implications: None as a direct consequence of this paper.
Stakeholders: The Trust, Staff, Patients
Recommendation(s): It is recommended that the Trust Quality Committee receive and note the information provided in this paper and take assurance for how safe staffing is managed, recruited, and retained to keep women and babies safe within Maternity services.
Report Author: Alison Murray, Divisional Deputy Director of Midwifery

Background

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

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

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

Birth Rate at Whiston Maternity Site

MWL maternity services utilises scenario-based forecasts based upon the previous years projected births as per national recommendations (NICE 2015). The rationale for utilising projected birth rates to plan for midwifery staffing is to estimate the potential resource impact associated with recommendations regarding midwifery staffing ratios and provide a woman

in established labour with supportive one-to-one care that are essential for safe midwifery care.

Births

The number of births at MWL Whiston site between 1st July and 31st of December 2024 was 1800 which was a decrease of 62 births (3.3%) from the previous six-month reporting period and a decrease of 7.6% compared to the same reporting period in 2023.

Month	July	Aug	Sept	Oct	Nov	Dec	Total
2024/25 Births	284	302	341	278	307	288	**1800**
2023/24 Births	311	351	329	325	316	316	**1948**
Variance	-27	-49	12	-47	-9	-28	**-148**

Bookings at MWL Whiston site between 1st July and 31st of December 2024 were 2005 which identifies a decrease of 71 bookings (3.4%) compared to the previous six-month period, with a 1.7% decrease compared to the same reporting period in 2023. Figures for Q3 specifically present an overall positive increase in the number of women choosing to book for Maternity care at MWL Whiston

Month	July	Aug	Sept	Oct	Nov	Dec	Total
2024/25 Bookings	343	326	327	368	332	309	**2005**
2023/24 Bookings	361	364	315	352	359	288	**2039**
Variance	-18	-38	12	16	-27	21	**-34**

Workforce Planning - BIRTHRATE PLUS® and Maternity Staffing Establishments

The Maternity Incentive Scheme (MIS) Year 6 Safety Action 5 requires that Trusts demonstrate an effective system of midwifery workforce planning. Birthrate Plus® (BR+) is a recognised tool for workforce planning and strategic decision-making.

The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG

BR+ is the only nationally endorsed tool for calculating maternity staffing levels. The methodology is based on an assessment of clinical risk and the needs of women and their babies during the antenatal period, labour, birth, the immediate post-delivery period, and the postpartum period utilising the accepted safe standard of one Midwife to one woman in labour. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives safe care in labour. BR+ determines the total midwife hours needed and therefore the staffing required, to deliver midwifery care to women across the whole maternity pathway using NICE guidance and acknowledged best practice based on clinical complexity of women who use the service.

Each individual service has their case mix identified using 5 different categories (Cat 1- V) with the lower the score the more normal the processes are for labour and birth and the higher scores indicating when a mother and/or baby require a very high degree of support or intervention. Together with the case mix, the number of midwife hours per patient/client

category plus extra midwife time needed for the complicated categories of III, IV & V and calculates the clinical staffing for the annual number of women delivered. Additionally included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

The most recent BR+ workforce review was commissioned for Whiston, with a final report being received in October 2022. The report was based on the annual activity of the FY 20/21- and three-months case mix data obtained for the months of August – October 2020.

The BR+ report is inclusive of a 22% uplift for annual leave, sickness and study leave and the report recommended a clinical workforce establishment of 175.47wte inclusive of 9% for non-direct clinical midwifery roles. The report also details that the addition of other support staff that do not contribute to the clinical establishment will be necessary (e.g. Band 2 HCAs for the effective functioning of the ward).

The report also identified that the proportion of the case mix had shifted from the previous BR+ study undertaken in 2016, with more women in the higher categories which reflected an increase in induction of labour rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions: as such this demonstrated an increase in the clinical workload hours required to provide safe care for each woman. This is consistent with the national trend of intervention as providers have implemented the recommendations of Saving Babies Lives Care Bundle and greater maternal choice.

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

The report highlighted that the Generic case mix in 2020 indicated that 55.6% of women were in the 2 complex categories IV and V, which was below the average for England of 58%. There was no comparative data in the 2016 report for this.

The establishment figures provided to BR+ were correct at the time of submission of the data, however changes to the funded establishment occurred in 2022 following the TUPE transfer of staff from the Bridgewater Community Trust that increased staff, activity, and the respective budgets. Additional changes were implemented in 2023 thereby increasing the funded establishment because of adding Ockenden funded monies following this transfer and by reorganisation and realignment of existing vacancies.

The below table provides the funded and contracted establishment for the midwives/ MSW providing direct and non-direct clinical midwifery care as of 31st December 2024.

Direct clinical care

Midwives	Funded (WTE)	Contracted (WTE)	Variance (WTE)
Band 7	19.80	22.43	+2.63
Band 5/6	123.26	124.44	+1.18
Band 3 MSW	25.16	18.07	-7.09
Total	**168.22**	**158.56**	**-3.28**

Non-direct clinical care

Midwives	Funded (WTE)	Contracted (WTE)	Variance (WTE)
8 and above	6.00	6.00	6.00
Band 7/6	8.39	10.59	+2.20
Total	**14.39**	**16.59**	**+2.20**

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

The Trust Board has agreed to substantively over establish by 6.00 WTE to cover maternity leave which is maintained, and therefore the maternity funded establishment for the provision of direct midwifery care as of the 31st December 2024 is in line with the recommendations of the BR+ workforce review.

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

The BR+ report identified that 14.49 WTE is recommended as the staffing requirement for non-direct clinical midwifery roles based on 9% of the total clinical WTE. The funded establishment in 2024/25 is 14.39 WTE but does not include the non-recurrent external funding received for the band 7 posts which are a 0.8 WTE Bereavement midwife, 1 WTE preceptorship/ workforce midwife and 0.4 preterm birth midwife which do appear in the contracted posts. There is an expectation of continuation of these roles once external funding is discontinued, and a business case will need to be developed.

The funded establishment for 2024/25 is 182.61WTE which is in line with the recommendations of the BR+ assessment.

Currently the Divisional Director of Midwifery who has a responsibility for Womens and Children's services are included in the non-direct clinical care midwifery staffing, and due to time being allocated for other roles in the portfolio in the new divisional structure and not exclusively for the leadership of midwifery services, the contribution of this post as 1.0 WTE will need to be considered.

The BR+ report analysed data and acuity for the current model of care provided within the Whiston maternity service and did not reflect any future or continuity of carer caseload teams. The maternity service will need to consider utilising the Continuity of Carer deployment tool to assist with determining the required additional number of midwives needed to deliver MCoC at full scale as we progress through the revised MCoC action plan which is currently paused following executive agreement. At present this tool is not endorsed by NHS England.

It is requirement of the MIS that a BR+ assessment is undertaken as a minimum every three years and therefore should be commissioned in 2025 for MWL. This will be the first study that will be commissioned as an MWL Trust and following the TUPE transfer of maternity staffing from Bridgewater Community Trust in 2022.

Maternity Staffing (Planned versus Actual)

Maternity has a process for daily review of planned versus actual staffing. Additionally, twice weekly meetings are held to monitor staffing fill rates and to allocate bank shifts to ensure consistent and safe staffing levels and mitigate staffing shortages.

One of the main service priorities is to maintain safe midwifery staffing levels. Maternity staffing and acuity are assessed on a 4hrly basis by the Maternity Bleep Holder and should staffing fall by the numbers of midwives to provide safe care, the Maternity Escalation Guideline is followed which includes the redeployment of staff. Midwives and MSW undertake a rotational training programme, allowing midwives to rotate between all clinical areas, ensuring a workforce that are skilled to work across all clinical areas of the maternity service. The Maternity Bleep holder consistently reviews staffing with the aim of redeploying non- direct care givers to address periods of high acuity in clinical activity to maintain a safe clinical staffing ratio.

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The Maternity bleep holder documentation contains comprehensive accounts of planned versus actual staffing which is completed daily identifying the staffing and activity status. Any redeployment or escalation is recorded on this documentation. A daily sit rep is also completed by 11am each day and submitted to the LMNS. This identifies current activity, escalation undertaken and hot spots with the ability to request a 'Gold' command meeting and formally request or offer mutual aid to other providers at a system level.

Maternity Workforce Measures

Recruitment

There is an ongoing rolling recruitment programme to address any deficits in vacancies as early as possible and be proactive in covering prospective maternity leave, requests to reduce contracted hours and retirements.

6 Internationally Educated Midwives (IEMs) have joined the Trust since November 22 under the national scheme; however, 1 midwife chose to return home. All IEMs are at various stages since arrival and have required an enhanced level of support and bespoke training plans in addition to the standard orientation and induction plan but are all now in receipt of their NMC PIN and are working in the clinical numbers as registered Midwives, supported by our workforce and pastoral support midwife, and members of the team.

During Q2/Q3 15.64 WTE Midwives commenced in post. This was inclusive of a Deputy Director of Midwifery appointed on a six-month secondment to cover the secondment of the Head of Midwifery to the Director of Midwifery post, and a Maternity Matron with a portfolio of responsibility of Intrapartum and Maternity Triage completing the structure for the senior team.

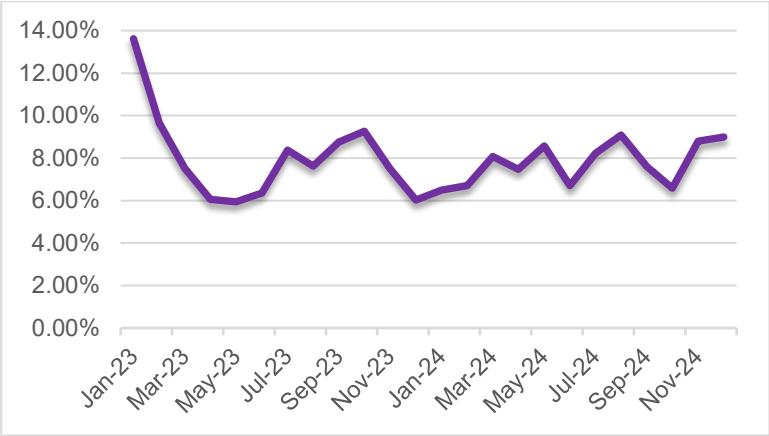
14 newly qualified midwives (12.64 WTE) joined Whiston at the end of Q2 to undertake their preceptorship on receipt of their NMC PIN following completion of their pre-registration studies alongside an experienced midwife (1.00 WTE) who had recently relocated to the area. Proactive recruitment has occurred to ensure those who have reduced hours, submitted notice of retirement or are leaving the organisation in Q4 are being replaced. At the end of Month 9 the service had no actual Midwifery vacancies and 7.09WTE MSW

vacancies, however 4.84WTE MSW were currently undergoing recruitment checks with projected start dates planned by Month 11.

Sickness

	July	Aug	Sept	Oct	Nov	Dec
Sickness 2024/25	8.23%	9.09%	7.61%	6.59%	8.80%	8.99%
Sickness 2023/24	8.37%	7.62%	8.76%	9.26%	7.51%	6.03%

There has been a reduction in the level of sickness in 2023 since the 13.62% rate in January 2023 for all Maternity staff including Covid-19 related sickness figures, however seasonal fluctuations continue to occur, and sickness remains above trust target of 4.5% which has been allocated as part of the headroom uplift. It is noted that sickness in Cheshire and Merseyside ICB for Maternity services is higher than other systems, and therefore the regional team have commissioned a deep dive to understand the reasons.



Sickness and absence management is monitored in accordance with policy supported by HR and HWWB. Divisional sickness reviews continue as does the emphasis on completing return to work interviews. Robust management practice continues, and assurance can be provided that where there is LTS sickness, cases are managed in line with policy with the majority of current LTS cases in the 0–3-month timescale.

Age Profile of Midwifery Staff

The table below indicates the age profile for Midwifery staffing with the largest staff group currently being aged 26-30 years of age. The maternity service had a number of leavers in FY 23/24 due to retirement which has impacted on the experienced skill mix. 50% of the Midwifery workforce are now 40yrs or younger and therefore it is anticipated that overcoming years we will see a greater impact of maternity leave unavailability on the establishment.

Age Band	%
21-25	7.34
26-30	13.04
31-35	12.77
36-40	16.58
41-45	12.50
46-50	7.88
51-55	10.87
56-60	11.41
61-65	6.25
66-70	0.82
>=71 Years	0.54
Total	**100.00%**

Whilst there is currently an agreement to over-recruit to BR+ recommended establishment by 6.00WTE Midwives, this may need to be reviewed in view of a changing demographic of an entirely female workforce. At the end of Q3 12.04WTE Midwives were unavailable and on maternity leave.

Quality of Care Measurements

Midwife to Birth ratio

The LMNS have been asked to support in looking at a review across C&M to ensure that the calculation of the midwife to birth ratio is standardised and consistent for all providers, specifically relating to non-direct care giving staff, DS shift coordinators and ward managers and if they are included or excluded in the calculation. MWL currently use the formula and methodology suggested by BirthRate Plus to produce the calculation.

Date	Midwife to Birth ratio
July 24	1: 27
Aug 24	1: 29
Sept 24	1: 33
Oct 24	1: 24
Nov 24	1: 27

Dec 24	1: 26

Supernumerary Shift Coordinator on Delivery Suite

The role of the Delivery Suite Shift Coordinator is a key role in the intrapartum area and are present 24/7 and are a recommendation within the Ockenden Report. The Delivery Suite Coordinator is supernumerary which is a pivotal role to enable them to undertake their role effectively in providing an overarching view, effective leadership, clinical expertise and facilitating communication between professionals whilst overseeing appropriate use of resources. The shift co-ordinator is rostered independently from the core midwifery staffing, and this is evidenced in e-roster with a distinct marker against the shift coordinator indicating supernumerary status.

Date	Supernumerary Shift Coordinator
July 24	100%
Aug 24	100%
Sept 24	100%
Oct 24	100%
Nov 24	100%
Dec 24	100%

One to One Care in Labour

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

Date	One to One Care in Labour
July 24	100%
Aug 24	100%
Sept 24	100%
Oct 24	100%
Nov 24	100%
Dec 24	100%

Midwifery Red Flag Events

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

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

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

- Delayed or cancelled time critical activity.

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

Red Flag Event	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Total
Delayed or cancelled time critical activity	0	0	0	0	0	0	**0**
Missed or delayed care	0	0	0	0	0	0	**0**
Missed medication	0	0	0	0	0	0	**0**
Delay of more than 30 mins in pain relief	0	0	0	0	0	0	**0**
Delay of 15 minutes or more between presentation and triage	1	0	4	10	12	4	**31**
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	**0**
Delay of 2 hours or more between admission for induction	0	0	0	0	0	0	**0**
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	**0**
Any occasion when 1 Midwife is not able to provide continuous 1-2-1 care in labour	0	0	0	0	0	0	**0**
If Delivery Suite Coordinator was not supernumerary and the reason why?	0	0	0	0	0	0	**0**

There were 31 Midwifery Red Flags reported in Q2/Q3, all which related to a delay in 15 Minutes or more from presentation to triage. The national reporting standard for this Red Flag is a woman to be triaged within 30 minutes of attending, but as a maternity service we have chosen to reduce this to the 15 minutes as recommended within BSOTS (Birmingham Symptom specific Obstetric Triage System) which in line with Cheshire and Mersey LMNS providers as a local Midwifery Red Flag.

All midwifery red flags were reviewed by the Clinical Lead and Matron for the area and there were no additional incidents related to these delays in undertaking triage and no harm occurred.

All delays were due to a high acuity and capacity and numerous women attending simultaneously. Following targeted training in September around how to address and seek clinical support when simultaneous attendances occur, the departments saw an increase in red flags which represented an improved reporting culture, allowing the identification of themes and trends, but this has now reduced as systems and processes regarding escalation have now been embedded within the department. The new central telephone system has had a positive impact in ensuring all calls are answered with appropriate support and action taken at times, however an emerging theme of high volume of calls alongside triage breaches has been highlighted in the analysis and is being monitored by the department leads

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

Continuity of Carer

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

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

The Trusts current position for Continuity of carer is currently on hold which has been discussed at Board level. The current homebirth team provides full continuity of care to women once a decision has been made to birth at home which can be undertaken at any stage of a woman's antenatal pathway. The amethyst team continues to provide continuity to the most vulnerable women although they are currently unable to provide the intrapartum element of the model currently with the intrapartum support coming from the Delivery suite.

The BR+ report reflects the current model of care and does not provide any recommendations for the delivery of CoC. A full review using the National CoC workforce tool will be required to determine what additional staffing will be required to fully implement CoC going forward.

Summary

The number of births at MWL Whiston site between 1st July and 31st of December 2024 was 1800 which was a decrease of 62 births (3.3%) from the previous six-month reporting period. Bookings were 2005 which identifies a slight decrease of 34 bookings (0.6%) compared to the same period in 2023. However, it is important to not see the activity as numbers alone and recognise increasing complexities and shifts in case mix of women with increasing

induction of labour rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions.

The BR+ report is inclusive of a 22% uplift for annual leave, sickness and study leave and identified that 14.49 WTE is the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical WTE. The funded establishment is 14.39 WTE and aligns to the recommendations.

The non-direct clinical care band 7 posts include three fixed term externally funded posts (2.2WTE) which are included in the contracted figures but not in the funded establishment and a business case will be required the expectation is that these posts will be substantive once the external funding ends.

The BR+ report concluded that the required WTE for the provision of direct maternity care was 160.98 WTE and the current funded establishment is 168.22 WTE due to changes following TUPE transfer and inclusive of an agreement to establish by substantively an additional 6.0 WTE to cover maternity leave.

The funded establishment for 2024/25 is 182.61WTE which is in line with the recommendations of the BR+ assessment.

It is requirement of the MIS that a BR+ assessment is undertaken as a minimum every three years and therefore should be commissioned in 2025 for MWL. This will be the first study that will be commissioned as an MWL Trust and following the TUPE transfer of maternity staffing from Bridgewater Community Trust in 2022.

The service operates an ongoing rolling recruitment programme to reduce any deficits in vacancies as early as possible and be proactive in covering prospective maternity leave and retirements. At the end of Month 9 the service had no actual Midwifery vacancies and 7.09WTE MSW vacancies, however 4.84WTE MSW were currently undergoing recruitment checks with projected start dates planned by Month 11.

Headroom for the service is currently factored at 22%. This is inclusive of annual leave, sickness; however, this may need to be revisited in view of the increasing demand on the requirements of maternity safety training.

It was agreed to over establish by 6.00WTE Midwives to cover maternity leave. This may need to be revisited in view of a changing workforce demographic of an entirely female workforce.

Midwife to Birth ratio is between 1:24 and 1:33. The LMNS have been requested to review how this is calculated to ensure consistency across Cheshire and Mersey providers.

There has been 100% compliance noted for the provision of one-to-one care in labour and the availability of a supernumerary Delivery Suite shift coordinator for this six-month reporting period.

In the six-month period there were 31 Midwifery Red Flag events reported, which has been an increase but is considered to be due to an improved reporting culture following focused training in the Maternity triage department. All Midwifery Red Flags were related to a delay of 15 minutes or more between presentation and triage as per BSOTS standard. All were reviewed by the Clinical Lead and Matron for the area and there were no additional incidents related to these delays in undertaking triage and no harm occurred.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	26 February 2025
Agenda Item	**TB25/016**			
Report Title	Safeguarding Annual Report 2023/24			
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Presenting Officer	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

The Safeguarding Annual report for 2023/2024 provides an overview of safeguarding adults and safeguarding children activity for the period 01 April 2023 to 31 March 2024. The purpose of the annual report is to inform the Board of safeguarding activity, providing assurance to the Board that the organisation has robust processes in place to safeguard those who use Trust services, and to highlight areas of challenges in safeguarding provision.

Executive Summary

All NHS bodies have a statutory duty to ensure they make arrangements to safeguard and promote the welfare of children and young people, to protect adults at risk from abuse, and support the Home Office Counter Terrorism strategy (CONTEST), which includes a specific focus on PREVENT (preventing violent extremism / radicalisation). Some of the key legislative frameworks to support safeguarding include: The Children Act (2004); Working Together to Safeguard Children (2023); Mental Capacity Act (2005); The Human Rights Act (1998); The Care Act (2014); Equality Act (2010).

The CQC fundamental standards require the Trust to ensure that suitable arrangements are in place to ensure that all service users are protected from the risk of abuse, and that internal processes are in place to reduce the potential for abuse.

The Trust Safeguarding Team based at the Whiston, Southport and Ormskirk sites is responsible for ensuring that robust and effective systems are in place to support the Trust in working effectively to safeguard the un-born, children, young people and adults who are at risk of abuse or neglect.

The Safeguarding Team is a multi-functional team providing both operational and corporate responsibilities across the hospital sites. The Whiston site team support the key adjoining boroughs of St Helens, Knowsley and Halton, with Southport and Ormskirk site teams supporting Sefton and West Lancashire. The team work closely with partners and support the work of the Local Safeguarding Boards/Partnerships for adults and children.

The report details the effectiveness of safeguarding arrangements for children, young people and adults, including the Mental Capacity Act (MCA) during 2023-2024. It illustrates continued engagement with key partners and demonstrates compliance with the requirements and key objectives of the Local Safeguarding Boards/Partnerships. The aim of this report is to provide an overview of the key developments, progress, achievements and challenges for the Safeguarding Team.

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable

Recommendations	
The Board is asked to note the 2023/24 Safeguarding Annual Report.	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
	SO3 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Mersey and West Lancashire Teaching Hospitals NHS Trust

Safeguarding Team Annual Report 2023/24

Authors: Sharon Seton and Anne Monteith

Assistant Directors of Safeguarding

Contents

Glossary of terms

AED	Accident and Emergency Department
ASC	Adult Social Care
CBU	Clinical Business Unit
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CE	Child Exploitation
CP	Child Protection
CQC	Care Quality Commission
CP-IS	Child Protection Information System
CSC	Children's Social Care
CSAP	Children's Safeguarding Assurance Partnership
CSPR	Child Safeguarding Practice Review
DBS	Disclosure and Barring Scheme
DARDR	Domestic Abuse Related Death Review
DoLS	Deprivation of Liberty Safeguards
EHCP	Education and Health Care Plan
ESR	Electronic Staff Records
FGM	Female Genital Mutilation
GMC	Greater Medical Council
HSVLO	Health sexual violence liaison officer
ICB	Integrated Care Board
ICON	This is a babies cry and its ok campaign.
IDVA	Independent Domestic Violence Advisor
ISVA	Independent Sexual Violence Advisor
JTAI	Joint Targeted Area Inspection (Ofsted, CQC, IPCC)
KPI	Key Performance Indicator
LD	Learning Disability
LA	Local Authority
LADO	(Local Authority) Designated Officer
LPS	Liberty Protection Safeguards
LSAB	Local Safeguarding Adult's Board
LSCP	Local Safeguarding Children's Partnerships
MACSE	Multi Agency Child Sexual Exploitation
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
MHLT	Mental Health Liaison Team
MSP	Making Safeguarding Personal
NHSE	National Health Service England
NHSI	NHS Improvement
NMC	Nursing and Midwifery Council
RAG	Red / Amber / Green
S&O	Southport and Ormskirk Sites
Section 42 Inquiry	Safeguarding Adults investigation coordinated by the Local Authority
WSTHN	Whiston, St Helens and Newton Sites

1. EXECUTIVE SUMMARY

1.1. The safeguarding annual report for 2023 / 2024 provides an overview of Safeguarding Adults and Safeguarding Children activity for the period 1st April 2023 – 31st March 2024. The purpose of the annual report is to inform the Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Quality Committee of safeguarding activity, providing assurance that the organisation has robust processes in place to safeguard those who use Trust services, and to highlight areas of challenges in safeguarding provision.

1.2. All NHS bodies have a statutory duty to ensure they make arrangements to safeguard and promote the welfare of children and young people, to protect adults at risk from abuse, and support the Home Office Counter Terrorism strategy (CONTEST), which includes a specific focus on PREVENT (preventing violent extremism / radicalisation). Some of the key legislative frameworks to support safeguarding include: The Children Act (2004); Working Together to Safeguard Children (2023); Mental Capacity Act (2005); The Human Rights Act (1998); The Care Act (2014); Equality Act (2010).

1.3. The CQC fundamental standards require the Trust to ensure that suitable arrangements are in place to ensure that all service users are protected from the risk of abuse, and that internal processes are in place to reduce the potential for abuse.

1.4. Safeguarding activity is subject to external oversight and scrutiny by the Care Quality Commission (CQC), NHS England and the Integrated Care Boards (ICB), and by the Local Safeguarding Children Partnerships (LSCP) and Safeguarding Adults Boards (LSAB).

1.5. The Safeguarding Team is a multi-functional team providing both operational and corporate responsibilities across the hospital sites. Following the transition to MWL the safeguarding resource has been maintained across sites. The team has worked collaboratively to commence reviewing and harmonising policies, processes and procedures. The Whiston site team support the key adjoining boroughs of St Helens, Knowsley and Halton, with Southport and Ormskirk sites teams supporting Sefton and West Lancashire. Key Performance Indicators (KPI) templates are being aligned into a joint submission and will be supported by a joint business meeting with St Helens and Sefton Designated Nurses.

1.6. From the quarterly submissions of KPIs, the Trust achieves a RAG rating of green in all areas other than not achieving 90% training compliance in all areas, and delays in the timeframe for the completion of Children in Care Initial Health Assessments.

2. INTRODUCTION

2.1. The team structure is set out in Appendix 2. As detailed in the Safeguarding Children and Young People: roles and competencies for healthcare staff intercollegiate document (2024) robust internal governance processes are in place to safeguard

children and adults with an Executive lead, a Named Doctor, Named Nurses for Safeguarding Children, Named Nurses Safeguarding Adults and Named Midwifes being in post. In accordance with LSCP's child death processes and detailed in Working Together to Safeguard Children (2023), the Trust has allocated Doctors for child deaths, who are senior paediatricians, and take a lead role in the child death review process.

2.2. The Safeguarding Team continue to strive for continuous and sustained improvement, in relation to the safeguarding policies being current, training compliance and responding proportionately and in a timely manner to safeguarding concerns.

Table 1: Key Achievements in 2023-2024 against the work plan for the previous reporting period

WSTHN	Update	
Improve training compliance	90% training compliance achieved in all areas other than level 3 adults and level 3 children's.	
Improve compliance with the Mental Capacity Act, including best interest decision making and recording and implementation of DoLS	The team has seen an improvement in DoLS authorisations, however there are still areas for improvement. The team is working with the Digital Nurses regarding the implementation of a digital DoLS process. In relation to best interest decisions and documentation, improvement is required, and the team target appropriate forums to share learning and cases when policy has not been followed.	
Review and harmonise safeguarding policies and processes to support the transaction with Southport and Ormskirk hospitals.	For this reporting period the team commenced the review of all safeguarding policies	
Improve implementation of learning from Safeguarding Adult Incidents investigated by the Local Authority	The Safeguarding Team now complete a DATIX for each Section 42 raised against the Trust, the outcome of the enquiry is uploaded and the ward or department complete appropriate action plans. Themes and trends are shared within the safeguarding newsletter and safeguarding reports.	
Utilise digital technology within the current IT systems to streamline and improve referral processes into the Safeguarding Teams	The Safeguarding Team has worked with the Digital Nursing Team to introduce electronic referrals via Care flow Connect.	

S&O	Update	
We will align safeguarding processes and practice across the new organisation and develop ways of working across the teams	For this reporting period the team commenced the review of all safeguarding policies	
We will ensure the Safeguarding Team undertake Trauma Informed Training, incorporating the principals into their practice	All team members have completed training	

We will develop and embed the role of the HIDVA, increasing staff awareness in relation to domestic abuse, and the potential opportunity for support during health appointments and attendances	Developed the HIDVA and HISVA roles across the S&O sites, delivering bespoke training, providing drop-in sessions and strengthening processes for supporting staff who are victims of domestic abuse. Development of a Business Intelligence (BI) report to develop a detailing patient with a domestic abuse alert attending the Trust, this enables the HIDVAs to review and identify any missed opportunities.	
We will ensure the Trust is compliant with the requirements of the Domestic Abuse Act (2021).	Completed	
We will ensure the Trust is compliant with the Serious Violence Duty (2022)	On going for current year to provide assurance that correct reporting and notification is being undertaken	
We will ensure compliance with the NICE Guidance 'Integrated health and social care for people experiencing homelessness,' (2022)	Completed mapping exercise and developed information and flow charts for use in the clinical areas and updated the intranet page	
We will ensure the Trust is meeting its statutory responsibilities of the SEND agenda	This is ongoing to provide assurance of the Trust's statutory SEND responsibilities.	
We will develop an internal process for identifying patients who are homeless or at risk of homelessness to ensure the trust is fulfilling its "Duty to Refer" requirements	A homelessness report developed in conjunction with BI to enable the Safeguarding Team to easily identify this cohort of vulnerable patients when they attend AED	
We will implement the Oliver McGowan e-learning for all staff	e-learning training implemented Implementation of the Rapid Risk Assessment document.	
We will review the continued provision of Personal Safety Training engaging with colleagues at WSTHN to ensure this is across all sites	Ongoing business case being led by colleagues in Risk	
We will collaborate with the Sefton MASH Team to streamline information sharing	Completed	
We will provide partner support to the Sefton Children's Social Care Improvement plan	Ongoing	
We will support Lancashire's review and implementation of new MARAC process	Completed	
We will become a member of the Pre-Birth Protocol task and finish group in Sefton, supporting the 'Building Attachment and Bonds Service' (BABS)	Completed	
We will work with the BI Team to streamline the process for identifying and following up patients with LD and or autism who have missed an appointment	BI report developed detailing patients attending, current inpatients, missed appointments, awaiting appointments	

We will undertake a review of the S42 Memorandum of Understanding with Sefton Local Authority	Awaiting local Authority to sign	
We will increase staff awareness of advocacy and other services such as IMCAs	A suite of information developed, and intranet page updated	
We will undertake a review of the mental capacity training to improve compliance	Training adapted form two levels to one	
We will provide tools to support staff to complete 2 stage capacity assessments	A suite of tools developed and shared and intranet updated	
We will develop a suite of pathways to support clinical staff in safeguarding decision making and referrals	A suite of pathways developed and shared	
We will revise the mental health risk assessments used in Paediatric departments	Ongoing to develop final version	
We will continue to improve the completion of the safeguarding documentation and assessment in AED	Ongoing and awaiting implementation of digital documentation to improve compliance	
We will continue to ensure the development of a network of safeguarding ambassadors		
We will seek to maintain training compliance ensuring compliance to the intercollegiate documents	Compliance >90% in all areas other than children's level 3	
We will work with IT colleagues to develop and implement digital streamlined process	Ongoing	
We will review the ways of working of the team and make improvements that will support the safeguarding agenda	Development of Safeguarding Newsletter aligned to the one for WSTHN sites	

3. GOVERNANCE ARRANGEMENTS

3.1. During 2023/2024 following a review of internal reporting arrangements as MWL, the decision was made to report directly to the Quality Committee on a quarterly rather than monthly basis.

3.2. For both sites, during this period, the Safeguarding Assurance Groups (SAG) were in place. The meetings were attended by representatives from the Local Authority, Designated Nurses and Healthwatch. The meeting had regular senior representation, and an advice, alert, assure (AAA) report from the meeting was submitted to the relevant Quality and Safety Committees.

3.3. During this period quartile KPI reports were submitted to the relevant Place and scrutinised by the Designated nurses, after which assurance reports were provided to both sites. During this period the Assistant Directors of Safeguarding undertook business meetings with the relevant Designated Nurses. From Q1 2024/2025 the KPI submission will be Trust wide, with assurance and scrutiny from St. Helen's Place and shared with Sefton Place.

3.4. The completion of section 11 audits provide assurance to the LCSPs of the compliance with Statutory Safeguarding Children responsibilities.

3.5. A suite of safeguarding policies are currently all in date following the relevant approval process for each site.

3.6. The children's and adult teams provide collaborative working relationships with other departments in the Trust including Patient Safety Managers, Complaints Team, Human Resources for cases that meet safeguarding thresholds. The teams provide representation at internal meetings including Harm-Free Care, HAPU, Patient Safety, Community Patient Safety Panel, Falls, Departmental, Child Death Reviews. The Safeguarding Children's Team provide supervision in line with the supervision policy.

4. ENGAGEMENT WITH EXTERNAL PARTNERS

4.1. The Assistant Directors of Safeguarding provide membership at the relevant LSABs and LCSPs. Membership at the Boards ensures that the Trust is sighted on all aspects of the safeguarding agenda, and attending the Boards allows the Trust to influence the local and national agenda. It further allows the Trust to develop policies and practices that are aligned to the Local Safeguarding Boards/Partnerships.

4.2. The Assistant Directors of Safeguarding, Named Nurses and Safeguarding Practitioners represent the Trust at local Board sub-groups and at wider safeguarding partnership meetings. Attendance at the groups allows the Trust to have up-to-date knowledge and informs areas for focus within the team's strategic agenda. Membership allows the team to be part of the development of safeguarding and ensures that Trust processes are in line with partner agencies. Through these subgroups, the team can be involved in the development of policies, audits, tools, and training to meet the standards required by the LSABs and LCSPs.

4.3. The Safeguarding Children Teams provide representation for the management of child deaths, reporting to and attending the Child Death Overview Panel (CDOP), attending internal review panels and external multi agency meetings and sharing information with external partners.

4.4. The Safeguarding Team endeavour to provide 100% representation at all requested strategy meetings, child protection conferences and core group meetings when relevant to attend. Reports for these meeting may be provided verbally, written or via email, as requested. The Safeguarding Team support the Safeguarding Adult review (SAR) and Child safeguarding Practice review (CSPR) process and Domestic Abuse Related Death Reviews (DARDR) by providing requested chronologies; panel membership; ensuring participation at practitioner events. The Safeguarding Team provide representation at local MACE, CDOP and MARAC meetings. Prior to the meetings the team complete all requests for information within the given timeframe, and subsequent actions from these meetings are completed. The Safeguarding Team will support clinical staff to complete court reports, and the team ensure all reports are quality assured prior to submission.

5. TRAINING COMPLIANCE

5.1. Across all sites in this period a compliance of greater than >90% was achieved consistently throughout the year other than in level 3 safeguarding adult and children's training. This has been attributed to clinical pressures and turnover of staff.

5.2. The mental capacity training has been maintained greater than 90% for the WSTHN sites, but not for the S&O sites, although the training has seen a significant upward trajectory, which hopefully will continue to be evident in the next reporting period. The mental capacity training at S&O sites was reviewed and reduced to a single tier of 3 modules.

5.3. In Q4 the Executive Board was compliant at 94.4% as of March 2024

Table 2: Trust Safeguarding Training Compliance 2023 - 2024

WSTHN	Q1	Q2	Q3	Q4
Safeguarding Adults Level 1	94.3%	93.5%	92.8%	93.6%
Safeguarding Adults Level 2	91.9%	91.9%	92.4%	93.4%
Safeguarding Adults Level 3	92.4%	81.3%	88.5%	88.5%
Safeguarding Children Level 1	93.9%	93.9%	93.5%	93.8%
Safeguarding Children Level 2	91.4%	91.1%	91.2%	92.6%
Safeguarding Children Level 3	87.4%	87.8%	86.3%	86.8%
S&O	Q1	Q2	Q3	Q4
Safeguarding Adults Level 1	92.9%	92.8%	92.9%	93.8%
Safeguarding Adults Level 2	91.4%	92.2%	90.8%	93.0%
Safeguarding Adults Level 3	93.3%	100%	96.7%	96.7%
Safeguarding Children Level 1	93.3%	92.4%	92.6%	93.5%
Safeguarding Children Level 2	90.4%	90.8%	90.3%	92.1%
Safeguarding Children Level 3	91.8%	87.5%	85.5%	84.4%

Table 3: Mental Capacity Act and Deprivation of Liberty Training 2023 - 2024

WSTHN	Q1	Q2	Q3	Q4
Mental Capacity	90.4%	91.4%	93.1%	94.0%
S&O	Q1	Q2	Q3	Q4
Mental Capacity	74%	76.9%	76.2%	85.9%

5.4. Each month the Departmental Managers receive the Trust training report and can monitor their compliance levels.

5.5. E-learning is provided for Level 1 and Level 2 safeguarding adults; Level 1 and Level 2 safeguarding children and children's level 3* (*at the WSTHN sites), Mental Capacity Act (MCA); Deprivation of Liberty Safeguards; PREVENT Level 3 -5.

5.6. Face-to-face training is provided and updated yearly for level 3 adults and children's* training (*at the S&O sites), although those staff who are non-compliant can complete an e-reader that is updated each year.

5.7. In addition to the training above the Safeguarding Team delivery bespoke training including:

- Doctors' induction covering general safeguarding, MCA and DoLS
- International Nurses covering MCA and DoLS
- Bespoke sessions to clinical areas and ward staff covering safeguarding, MCA and DOLS
- Bespoke sessions to Managers covering disclosures of domestic abuse from staff
- Preceptorship training
- Bespoke training to other staff groups is delivered as requested

5.8. All relevant LSAB and LCSP training is shared through social media, Trust news and the Children's steering group.

5.9. Relevant Safeguarding Team members attend an array of multi-agency training to maintain their compliance to level 4 training.

6. SAFEGUARDING ACTIVITY

6.1. Adults

6.2. For adult safeguarding referrals, other than in an emergency when the Local Authority (LA) 'duty team' will be contacted, staff complete a referral to the safeguarding adult's team via the datix system for S&O sites, and via order comms for WSTHN sites. All safeguarding concerns will be quality assured and checked by the Safeguarding Team prior to submission to the LA; again, this excludes emergency safeguarding concerns out of hours.

6.3. The adult's team collates data regarding safeguarding referrals and safeguarding concerns raised within the Trust. The data is extrapolated from completed datix reports and databases and allows the team to identify areas of concern.

6.4. Across all sites in 2023/2024 there has been 2416 safeguarding concerns raised including domestic abuse and sexual abuse: 1250 for WSTHN sites and 1166 for S&O sites.

6.5. In addition, across all sites there has been 3836 applications for a DoLS authorisation with 1868 at the S&O sites, and 1968 at the WSTHN sites. For S&O sites this is comparable with 1857 in 2022/23. For WSTHN sites this is a 52% increase. Each of these authorisations is processed and quality assured by the Safeguarding Team prior to submission to the relevant LA.

6.6. Across all sites 572 of the concerns raised required a referral to the Local Authority. It is worth noting that not all referrals to the LA would have progressed to a safeguarding enquiry under S42 of the Care Act, 2014.

Table 4: Number of Adult Social Care Referrals per site

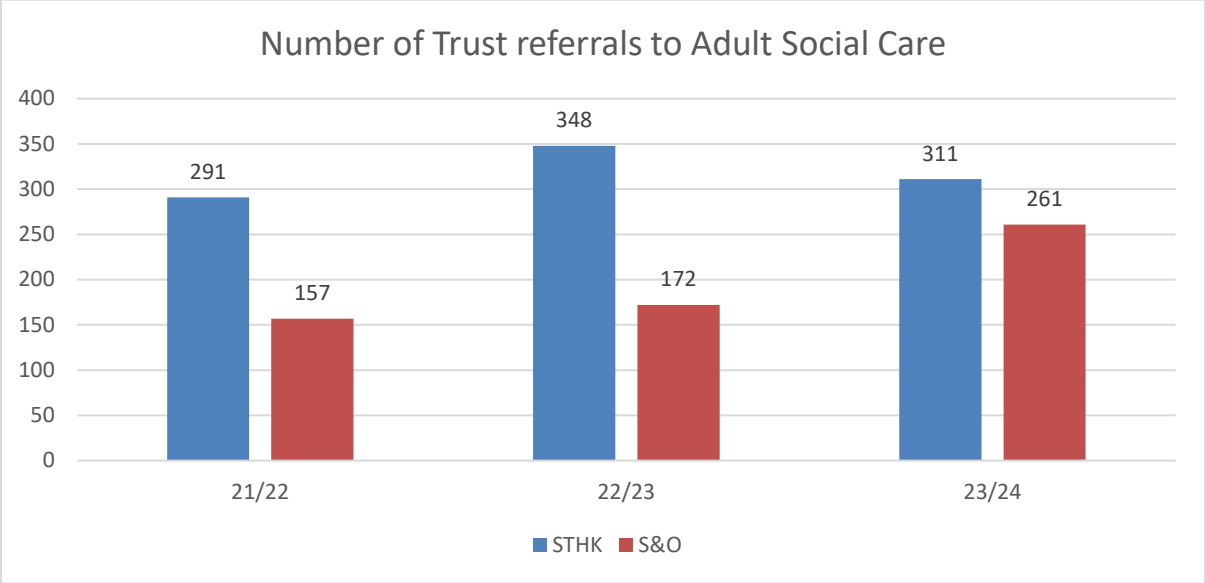
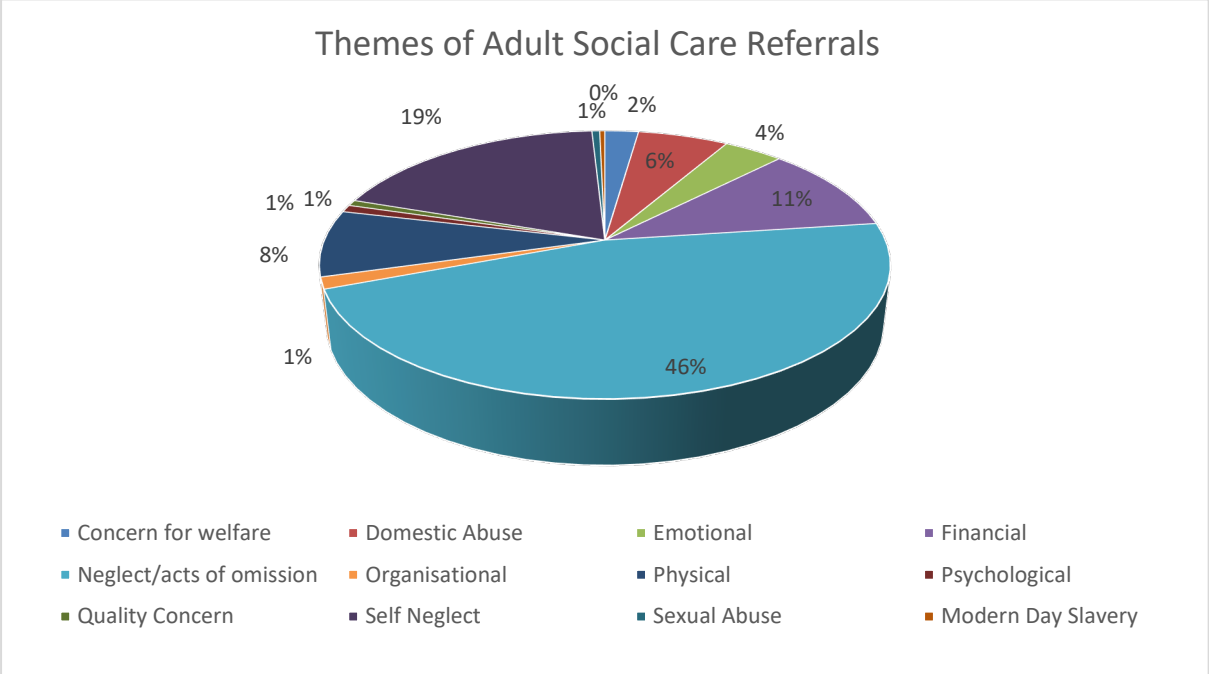


Table 5: Themes of Adult Safeguarding Social Care Referrals



N.B The teams across sites have slightly different categories for reporting

6.7. From the above neglect and acts of omission account for nearly 50% of the referrals with self-neglect accounting for nearly 20%.

6.8. The adult's team attend several meetings with partners to discuss and review any ongoing or current risk to individual patient/people, these include LA Strategy meetings, best interest meetings, multi-agency risk management meetings and discharge planning meeting. To note the disparity in figures below can be partially attributed to differences in process with the LA's serving respective MWL sites, where within Sefton and West Lancashire invites are only sent depending upon the complexity of the case being discussed.

Table 6: Number of Strategy meetings attended

Safeguarding Team								
	Q1		Q2		Q3		Q4	
	WSTHN	S&O	WSTHN	S&O	WSTHN	S&O	WSTHN	S&O
Strategy Meetings	30	Data not recorded	11	3	26	1	38	1

6.9. The adult team oversee two work-streams in terms of safeguarding referrals. The first relates to safeguarding alerts made by Trust staff. The second relates to safeguarding concerns raised against the Trust. The LA, under Section 42 of The Care Act, have the authority to request partners to investigate concerns raised.

6.10. All S42s against the Trust are sent either via the associated LA Safeguarding Team or Knowsley MASH to the Adult Safeguarding Team, who oversee the investigation and liaise with the LA regarding the outcomes. In this reporting period across all sites there were 140 enquiries or requests for information received. After initial information sharing the concern can be closed, which for S&O sites occurred in 46 enquiries received. Feedback regarding the outcome is not consistently shared with the Trust, although it is known for the S&O sites 38% were unsubstantiated with an outcome still required for 8%.

6.11. The themes from the S42s remains relatively consistent and are mostly in relation to concerns raised by external partners during the discharge process. The main learning from enquiries relate to incomplete communication, including lack of information sharing such as discharge checklist and summaries, body maps, transfer letters, or failure to request further assessments from Adult Social Care when care needs are known, or lack of referrals to community colleagues, there is a re-occurring theme regarding lack of medications provided on discharge. Themes are also raised at both Corporate Nurse Meetings and Ward Managers and Matrons meetings.

6.12. For WSTHN sites all outcomes are shared with the wards via DATIX, and the Ward Managers are responsible for adding action plans to improve practice. At the S&O sites all concerns raised against the Trust are discussed at weekly Patient Safety Meetings. Any enquiries requiring a detailed report and action plan are presented to

the Harm Free Care meeting to provide oversight of the investigation, learning and subsequent actions.

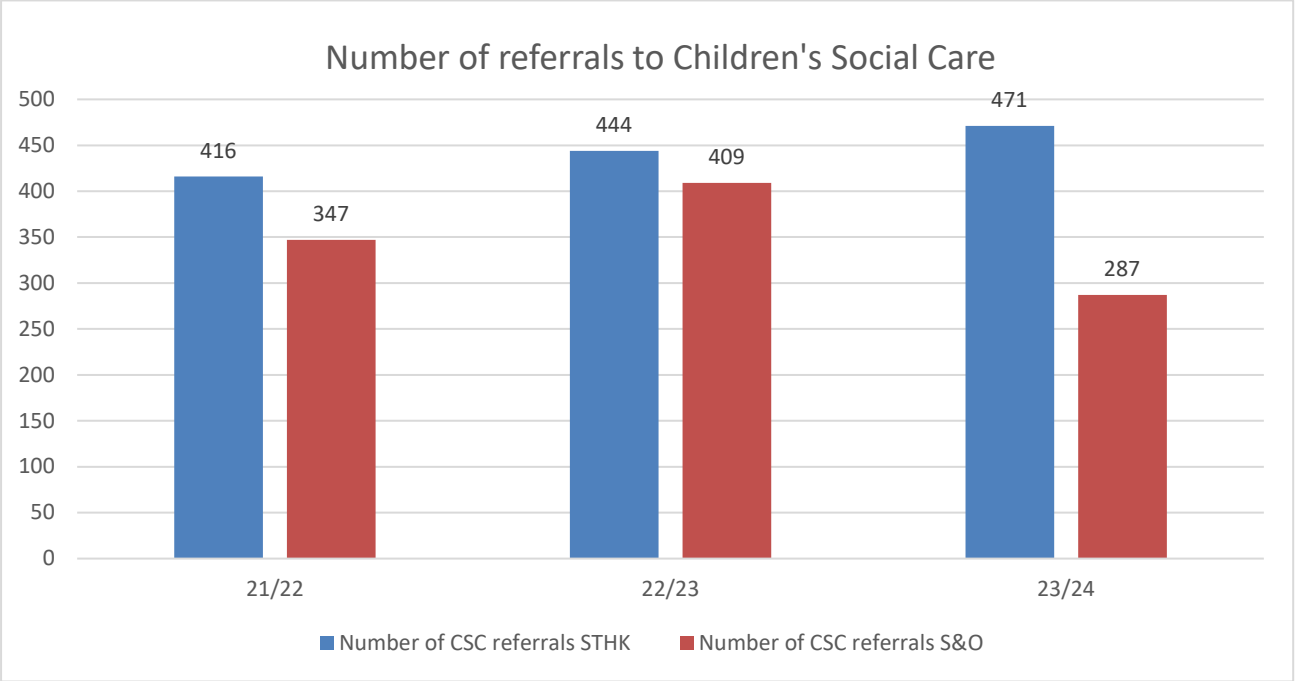
6.13. Making Safeguarding Personal

6.14. Where adults have capacity 'Making Safeguarding Personal' (MSP) allows them to express the outcomes they would want, and to uphold their right to refuse a referral, (where there is no concern regarding the wider public interest, or risk of serious harm to themselves). In accordance with the principal of MSP there were 62 individuals on the S&O sites who had capacity to refuse intervention, and a referral was not made. This is an 25% increase from 2022/2023. At the WSTHN sites there were no refusals under MSP.

6.15. Children and Young People

In 2023/2024 for the children's team across all sites there were 738 referrals to Children's Social Care, including Early Help.

Table 7: Number of Children's Social Care Referrals



6.16. CSC do not routinely share the outcomes of referrals therefore for 2023/2024 it not known exactly how many of the Trust's referrals proceeded to a 'child in need' and or S47, however for outcomes that have been received across all sites 350 progressed to either Early Help, Child in Need or Child protection enquiry (S47). It is worth noting the Safeguarding Team may receive the initial outcome but will not know the end outcome of the child and family assessment or S47.

6.17. The team provide 100% attendance at meetings where it is relevant and appropriate for the Trust to be represented. It is worth noting the number of records checked for each conference is significant as it includes reviewing the children's, parents' and significant other records. These meetings have included but not limited to:

Table 8: **Number of meetings attended**

Activity	21/22		22/23		23/24	
	WSTHN	S&O	WSTHN	S&O	WSTHN	S&O
Strategy Meetings	139	47	154	99	226	72
CP Conferences	94	25	96	41	164	31
Pre-birth assessment meetings	281	22	308	29	389	31

6.18. N.B The Team at S&O sites received invites to 893 child protection conferences, although were only required to attend 31.

6.19. The children's team is required to provide an extensive amount of safeguarding information to external agencies. A single request for information can involve searching the clinical records of several people, as the search can include a child, their siblings, their parents, grandparents and other members of the extended family. This remains extremely challenging for Sefton where the number of requests in this period was 1356, resulting in 6322 clinical records reviewed. Sefton LA are implementing a new referral process, and it is hoped this will reduce the number of enquiries to the team based at Ormskirk.

6.20. There is a disparity in the process for Case Conference invites by Sefton Children's Social Care, where all invites are forwarded to the Ormskirk Safeguarding Team, whereas the Local Authorities serving WSTHN sites only invite when there is identified involvement, usually when a woman is booked for ante natal care, or a child has a chronic or long-term health condition managed by practitioners within the Trust.

7. SUDDEN UNEXPECTED DEATH IN CHILDREN (SUDI)

7.1. The Trust meets its requirements in relation to the LSCP's child death processes as the Safeguarding Children's Teams ensure that national and local policy is followed in line with the Working Together to Safeguard Children, 2023. This involves relevant notifications to the Police, Children's Social Care and HM Coroner in the first instance, and subsequent information sharing processes include community partners, G.P, CDOP and the ICB. The Children's Teams provide representation at strategy and rapid review meetings for the purpose of sharing relevant information and inform the decision making.

7.2. Within WSTHN sites there were 5 sudden child deaths during 23/24. The relevant processes were initiated in all cases and internal child death review meetings undertaken. One case progressed to a rapid review by the LSCP; a Child Safeguarding Practice Review was not deemed necessary, although a local learning review was initiated, there were no significant actions or learning for the Trust.

7.3. Within S&O sites there were 7 child deaths during 23/24. The relevant processes were initiated in all cases. The Safeguarding Children's Team attended all necessary strategy meetings when applicable. In 4 cases the death was unexpected (SUDIC), and 3 of the deaths were expected. One of the SUDIC progressed to a rapid review and the Trust is awaiting the outcome to be shared.

8. DOMESTIC ABUSE and SEXUAL ABUSE

8.1. There is recognition that domestic abuse (DA) covers a range of behaviors, and relationships, and domestic abuse is recognised under The Care Act 2014 with its own category. The Domestic Abuse Act 2021 provides a legal definition of 'Domestic Abuse'. It emphasises that DA is not just physical violence, but it can also be emotional, controlling, coercive and economic abuse. Following the publication of the Act, the team updated the Domestic Abuse Policy accordingly.

8.2. At the S&O sites DA is supported by two Health Independent Domestic Abuse advisors (HIDVAs). Their role has been pivotal to managing cases of DA and increasing the awareness and reporting of DA. The HIDVAs have developed the service providing risk assessments, safety planning and onward referrals for both patients and staff victims of DA.

8.3. The Safeguarding Teams attend the relevant bi-weekly/monthly Multiagency Risk Assessment Conference meetings (MARAC), which are undertaken when there is an immediate risk of serious harm or death to the victim. The teams receive the information via MARAC coordinators and complete a review of all individuals listed within the case summaries. If individuals are known to the Trust any relevant information will be shared at the meeting.

8.4. In incidents and or disclosure of actual or suspected domestic abuse, staff use a domestic abuse risk assessment to determine the most appropriate referral. For high-risk cases a referral to the MARAC is undertaken by the Safeguarding Team, following a review of the datix and the risk assessment, with engagement of the person disclosing the abuse where possible.

Table 9: Risk assessments and referrals to MARAC (all sites)

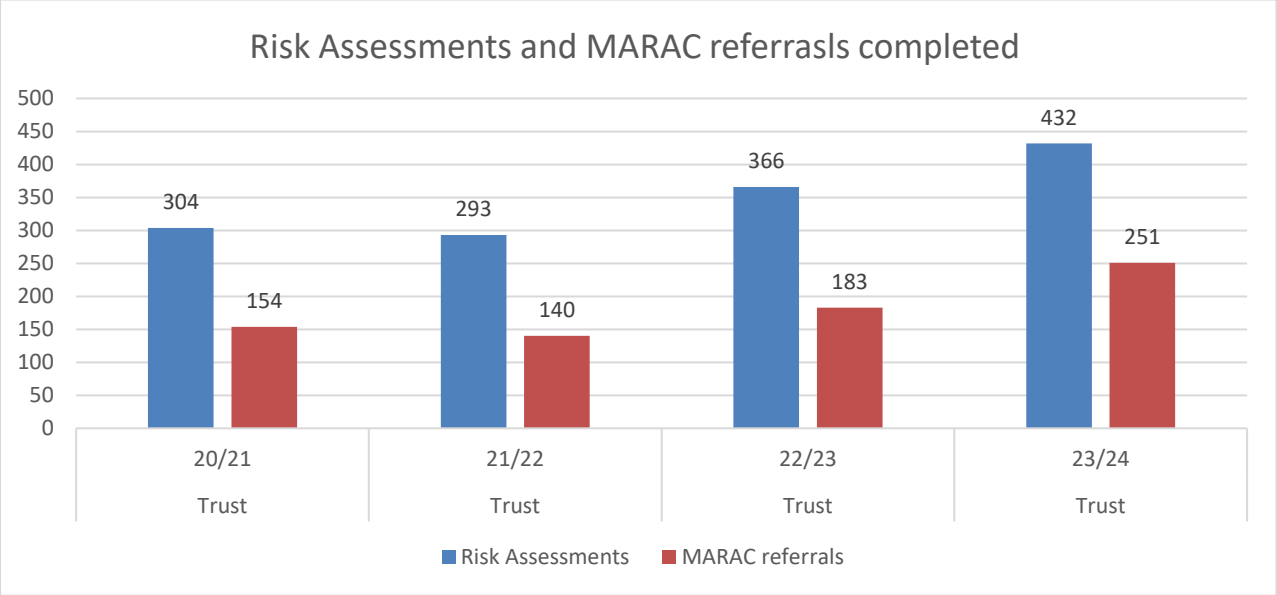


Table 10: Number of Assessments and MARAC referrals per site

	20/21		21/22		22/23		23/24	
	WSTHN	S&O	WSTHN	S&O	WSTHN	S&O	WSTHN	S&O
Risk assessments	189	115	173	120	246	120	345	87
MARAC referrals	96	58	96	44	128	55	196	55

8.5. For the WSTHN the number DA risk assessments completed has increased by 40% in 23/24, providing significant assurance that staff are able to recognise the indicators of domestic abuse, and respond appropriately to disclosures.

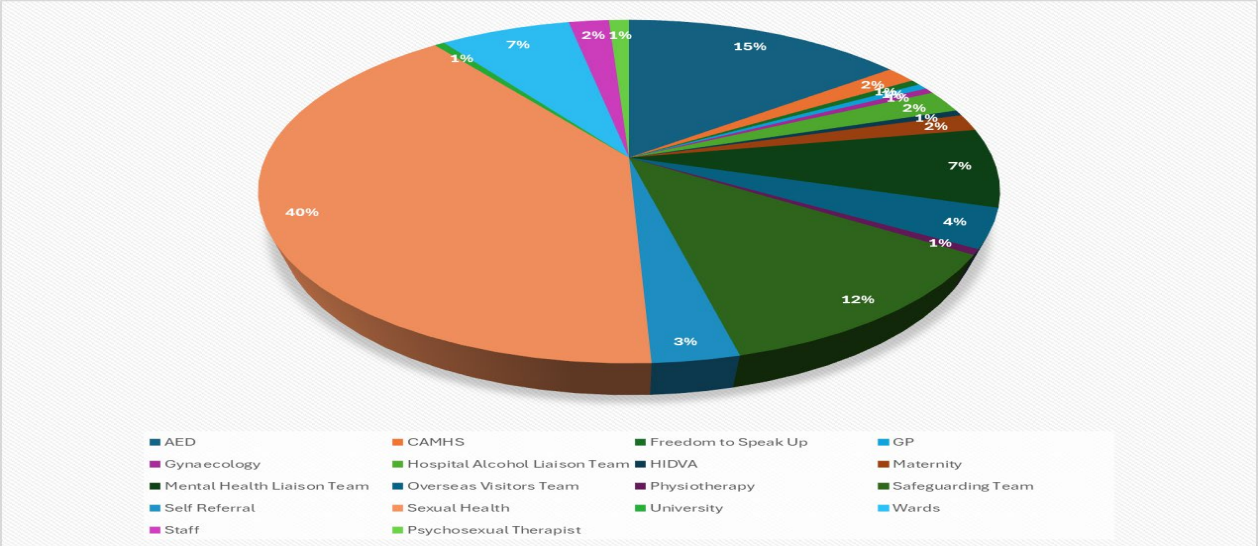
8.6. It is to be noted that victims can refuse a risk assessment or following a risk assessment decline further support and onward referral. While Safeguarding Practitioners use their professional judgment to refer to MARAC without consent, a referral may not be required if partners and support agencies are already working with the victim, and information has been shared with them.

8.7. The Safeguarding Team further provides support to staff who are the victim of domestic abuse.

8.8. **(S&O sites only) Health Independent Sexual Violence Adviser (ISVA)**

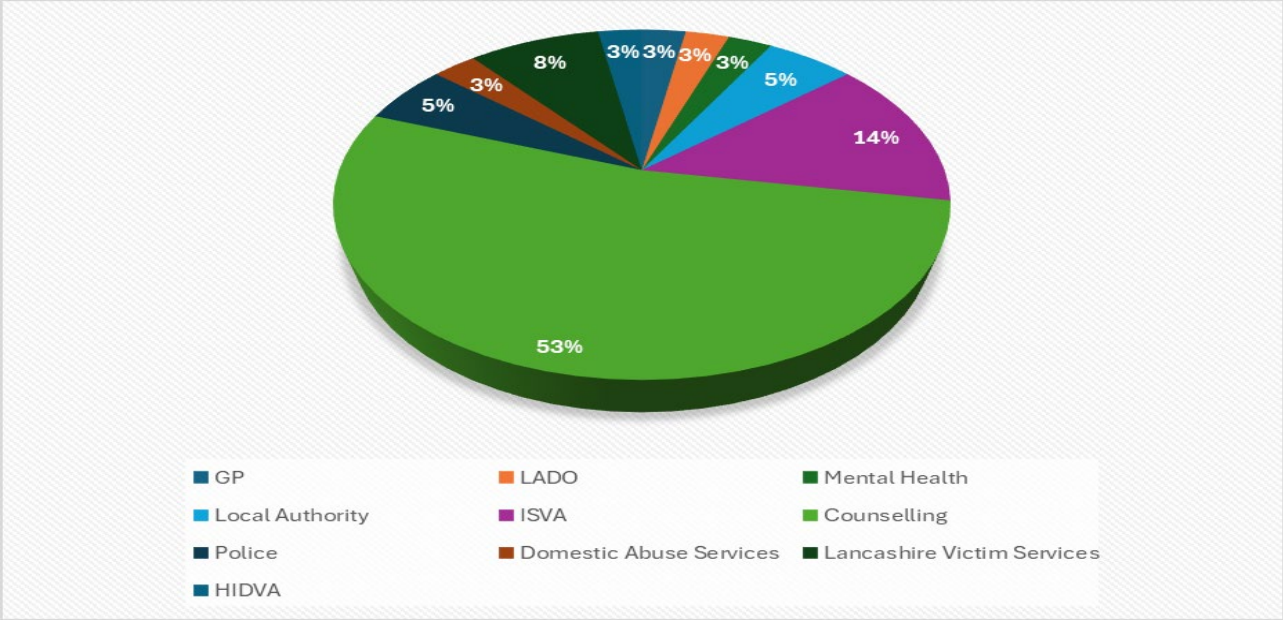
8.9. The Health Independent Sexual Violence Adviser (ISVA) is based within the Safeguarding Team. The role provides specialised support to victims of sexual abuse, male or female, aged 16 years and above, who have recently or in the past been subjected to any form of sexual abuse. In this year there have been 189 referrals from a range of sources.

Table 11: **HISVA Referral Source**



8.10. In this reporting period the percentage of patients attending the S&O sites who had experienced recent sexual abuse (in last 10 days) was 25%, with 75% reporting non-recent sexual abuse.

Table 12: **Referrals to Support Services and Partners**



9. DOMESTIC ABUSE RELATED DEATH REVIEWS (DARDR's)

9.1. During 2023/2024 the Trust has been notified of 6 DARDRs for which information requests were received. Extensive chronologies were submitted for 5 cases where

either the victim and or perpetrators were known to the Trust; to date 2 Individual Management Reviews (IMR) have been completed and submitted, although there have been no learning points identified. The Trust has provided representation for relevant panel meetings. In addition, the S&O sites completed 3 information requests for potential DARDRs.

9.2. The S&O has received confirmation that DARDR 18 will be commissioned. The Safeguarding Team identified a potential domestic abuse related death and notified the Police and Sefton Safety Partnership. Confirmation as to whether this will progress to DARDR's is to be provided. Confirmation has been received that DARDR 15 has been submitted to the Home Office and is scheduled to be heard at the Quality Assurance Panel on 22/01/25.

10. SERIOUS CASE REVIEWS (SCR) and CHILD SAFEGUARDING PRACTICE REVIEWS (CSPRs)

10.1. The Assistant Directors of Safeguarding and the Named Nurses attend and support local SAR and CSPR sub-groups and represent the Trust at relevant panel meetings.

10.2. Across all sites in this reporting period the children's Safeguarding Practitioners have supported the panel for 2 CSPRs, as the Trust has been directly involved with the two children. Appropriate learning has been shared internally.

10.3. Across all sites the Safeguarding Team has supported and shared information for 5 safeguarding rapid reviews, providing chronologies and representation at panel meetings. No cases have progressed to a CSPR. Three cases had no identified learning for the Trust. One case related to a child death where neglect was a potential feature, and the learning identified for the Trust related to recording the details of the home environment during visits, whether these are positive or negative. One case relating to over lay and did not identify any new learning and therefore did not proceed to a CSPR.

10.4. SAR referrals are submitted to the LSAB, who triage and decide if to undertake a review. Across all sites there have been 5 requests for information in relation to potential Safeguarding Adult reviews received in this reporting period. To date one is progressing to a SAR, and one progressed to a local learning review.

10.5. 1In addition to this, the Safeguarding Adults Team has submitted 2 referrals for potential SAR's, 1 for Lancashire and 1 for Sefton, both relate to concerns regarding self-neglect.

10.6. To date the reports have not been finalised, although the immediate learning and actions include:

- An update of the patient access policy to support vulnerable adults not brought to appointments
- Consideration for cares assessments for those caring for vulnerable adults

- Exploration of access to Merseycare EPRR for the Learning Disability Nurses to view the records of patients known to Community Services

10.7. The Safeguarding Team seek to review all learning from local SARs and CSPRs, and as a result will adapt processes and policies, documentation, training and share information to relevant staff.

11. MENTAL CAPACITY ACT and DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

11.1. The Mental Capacity Act 2005 (MCA) is an integral piece of legislation used by healthcare professionals. In 2009, DoLS was bolted onto the MCA 2005 to create a procedure enshrined in law to deprive people, who are assessed as lacking capacity, of their liberty (in their best interest). Any patient over the age of 18, who lacks capacity to consent to their arrangements (i.e. admissions to hospital), who is subject to continuous and effective supervision and control and is not free to leave, is defined as 'deprived of liberty,' and therefore a DoLS is required to safeguard their human rights.

11.2. This poses a challenge not only for acute Trusts but has also placed a heavy burden on the Supervisory Body (LA's), who are required to complete Best Interest Assessments and authorise a considerable number of DoLS in the community, as well as the hospital setting. As a result, after 14 days patients are deprived of their liberty under the principal of best interests.

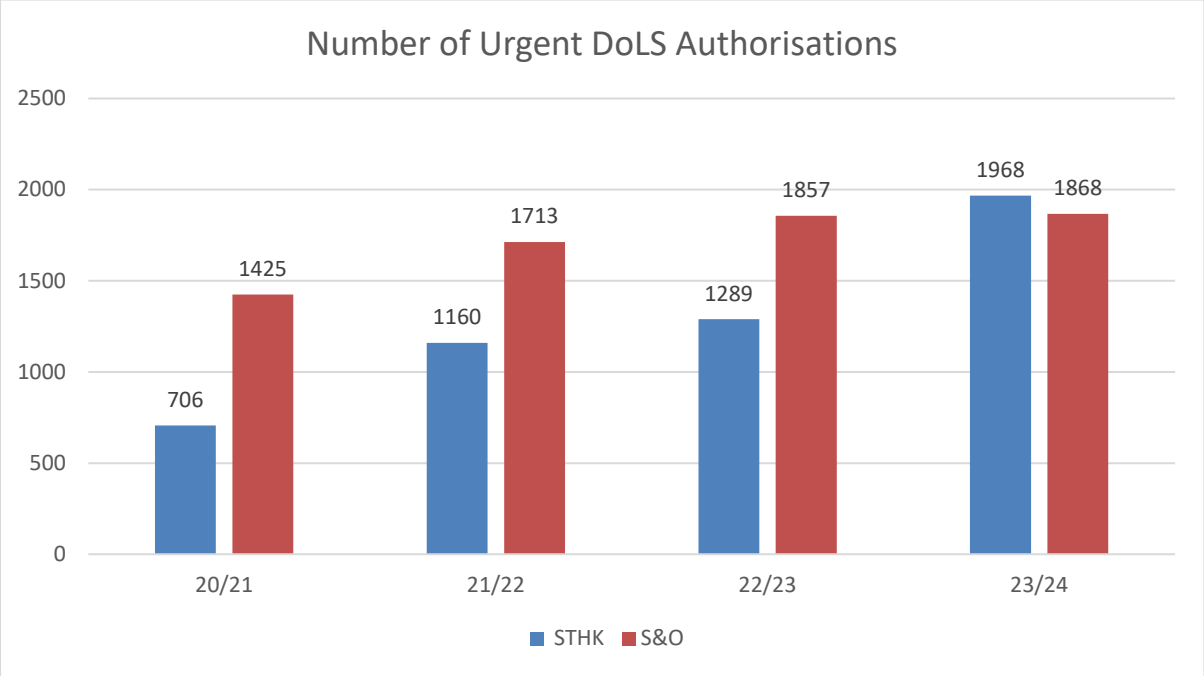
11.3. This is detailed in the Trust risk register which refers to patients who are placed under an urgent 14-day DoLS authorisation, which expires before the Supervisory Body has been able to complete a best interest assessment.

11.4. The Safeguarding Teams have robust systems for monitoring the DoLS process: all DoLS authorisations are checked and quality assured; if required the authorisation is adjusted before submission to the Supervisory Body. Ward staff are required to review and record daily the restrictive practices in place to ensure these are the least restrictive and proportionate.

11.5. The team sends an email regularly to the Supervisory Body, advising of patients who no longer require a DoLS, and the patients who are awaiting a Best Interest Assessment. When the team is aware they further escalate to the Supervisory Body, any patient who needs an urgent Best Interest Assessment for example, they strongly object to being in hospital, they are subject to a high level of restrictive practice, or they have been an inpatient for significant period.

11.6. Across all sites there has been 3836 authorisations for an urgent DoLS with 1868 at the S&O sites and 1968 at the WSTHN sites. For S&O sites this is comparable with 1857 in 2022/23. For WSTHN sites this is a 52% increase. Each of these authorisations is processed and quality assured by the Safeguarding Team prior to submission to the relevant Local Authority.

Table 13: Deprivation of Liberty Safeguards Applications



11.7. Those that are not authorised by the Supervisory Body are due to the patient being discharged before the assessment is undertaken; patients regaining capacity; patients who have deceased; the urgent authorisation lapses due to no assessment being undertaken by the Supervisory Body.

12. LEARNING DISABILITY

12.1. Patients who attend the Trust with a diagnosis of a Learning Disability or Autism should be able to expect high quality, personalised and safe care. The NHSE/I improvement standards for Acute Trusts include:

- Respecting and protecting rights of those with a Learning Disability, ensuring the Trust meets the Equality Act requirements, provides reasonable adjustments and flagging to identify patients and support the additional care required.
- Inclusion and engagement ensuring the patient, family and carers are all empowered and included in the care provided as a partnership
- Ensuring the workforce is resourced and skilled to care for those with a Learning Disability

12.2. Due to their experiences of both acute and chronic illness, people who are learning disabled have an increased attendance and admittance to acute general hospitals, and the demand from people with learning disabilities, their families and carers on specialist and general health service is expected to increase significantly in the future (Gates, 2011, as cited in Phillip, L. 2018).

12.3. The Learning Disability and Autism Practitioners (LDAP) demonstrate extensive value in relation to patient and care experience and providing staff support, developing relationships with the patient's family, and or carers.

12.4. The LDAPs have provided an extensive amount of support to ward staff; supporting ward-based care; the provision of reasonable adjustments; supporting DoLS and DNACPR decisions, facilitating a timelier discharge; providing ad-hoc learning disability and autism awareness sessions. They have established strong communications with community-based learning disability services, ensuring a collaborative approach to meeting the patient's care needs.

12.5. Improvements in this reporting period:

12.6. S&O sites:

- Continued to support the LD Volunteering role when at the 'Time to Shine' awards, 2023 the LD volunteer was awarded volunteer of the year
- The LDAP nominated as the 'everyday hero' and highly commended at 'Time to Shine' awards, 2023.
- Launched an electronic referral process to improve data collection and monitoring.
- Identified an LD Lead in cancer services.
- Undertaken a one-month pilot project with the appointments team to address 'was not brought/did not attend' rates for patients with a known diagnosis of LD and or Autism. Further work will be completed on the LDAP's return from maternity leave.

12.7. WSTHN sites:

- Implementation of the orange wrist bands to identify patients requiring reasonable adjustments, compliance will be audited in 2024/25
- Recruited a second Band 7 Learning Disability Nurse to support with significant increase in activity.
- Implementation of a Learning Disability Patient / Carer Forum to seek feedback and improve patient experience.

12.8. The LDAPs support the Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) agenda. The LDAPs ensures the Trust reports, within the required timeframe, the deaths of those with a learning disability and or autism. The LDAPs liaise with the LeDer reviewer to provide the required information and following the review feedback recommendations into the Trust Mortality Operational Group.

12.9. This year the Trust submitted 28 (17 at WSTHN and 11 at S&O) LEDER notifications.

12.10. As per internal mortality review process, all deaths for LD patients receive a Structured Judgement Review. It has been noted that improvements are required regarding the lack of evidence within the medical notes for the consideration of the Mental Capacity Act, specifically in relation to DNACPR decisions. It has been further noted that inaccurate information has been recorded on DNACPR forms. The Safeguarding Team are working collaboratively to improve practice

12.11. The LDAPs provide representation at local LeDeR steering groups, ensuring the Trust is sited on improvements required to improve the lives, and prevent unavoidable deaths of those with a learning disability and or autism.

12.12. The LDAP at S&O represents the Trust at the SEND Improvement Programme Meeting and the SEND Champion meetings and has established links with the SEND Leads in both Lancashire and Sefton.

12.13. The table below represents some of the activity undertaken by the LDAPs, although data is not currently collected in the same way.

Table 14: LDAP Activity

	Inpatients (excluding AED attendances)		Outpatients		Information sharing only	
	WSTHN	S&O	WSTHN	S&O	WSTHN	S&O
2021/22	418	Data not collected	170	Data not collected	58	Data not collected
2022/23	585	Data not collected	133	Data not collected	163	Data not collected
2023/24	654	332	135	769	410	Data not collected

*N B the LDAP at S&O sites was only in post from August 2022 and has undertaken maternity leave since December 2023, so data collection is incomplete

13. MENTAL HEALTH

13.1. Mental health Act Detentions

13.2. At S&O sites a Service Level Agreement (SLA) is in place to provide the Mental Health Act Administration. In contrast at WSTHN sites the Safeguarding Team undertake the Mental Health Act administration process for all patients detained on these sites. The Assistant Director of Safeguarding has sought approval for an extension to the SLA for Mersey Care to provide this role across all sites. Mersey Care are reviewing the resources they require to extend the SLA across all sites.

13.3. As per the table below the number of patients detained to the WSTHN sites has increased this reporting period, with continued complexities and concern relating to delayed discharges due to unavailability of mental health beds. To note the significant difference in the number of patients detained is partially attributed to a variance in process across sites, where at Whiston patients awaiting a bed from an AED attendance are detained to an in-patient area within AED, while patients attending Southport AED are not detained while awaiting a mental health bed.

Table 15: Number of Mental Health Detentions

	WSTHN	S&O
2021/22	118	Data not held by team
2022/23	102	Only part year data available
2023/4	114	38

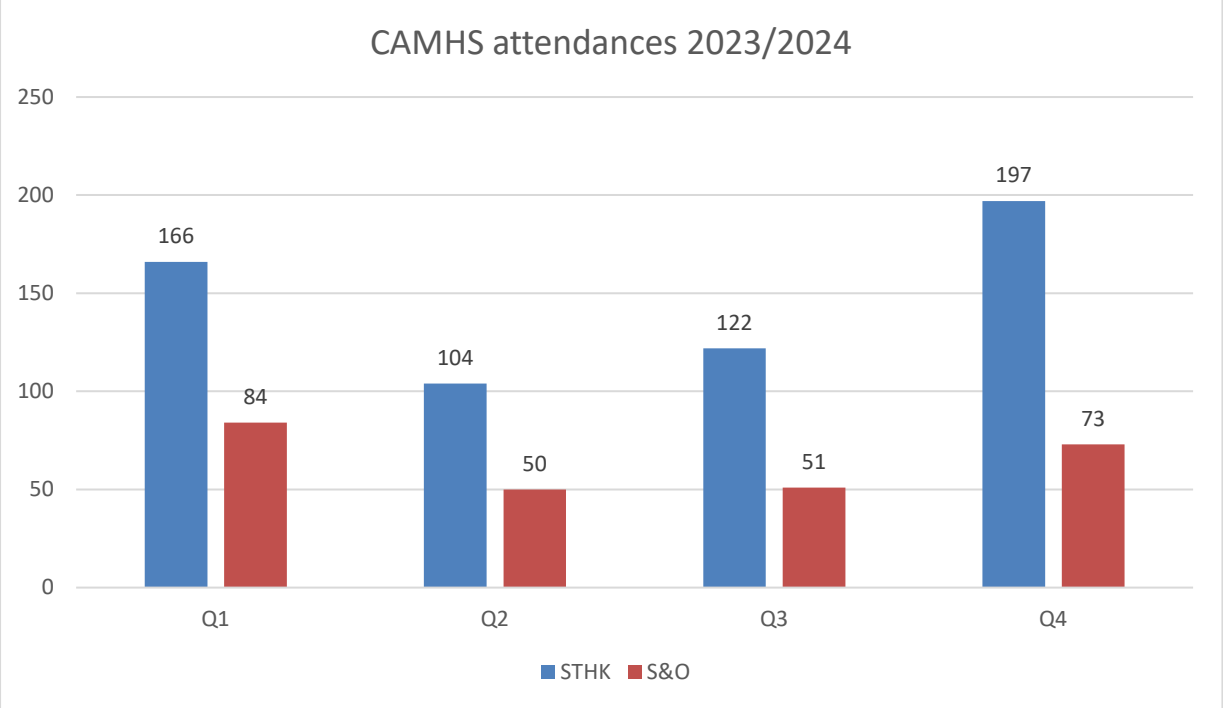
13.4. Tribunal Applications

13.5. Across all sites there were 11 formal requests for a tribunal by patients detained to the Trust. All tribunals were at the WSTHN sites, and in the absence of a Mental Health Administrator the process was undertaken by the Safeguarding Team.

13.6. Children and Adolescent Mental health Services (CAMHS)

13.7. CAMHS attendance for this reporting period are detailed in the Table 16. Over the year there has been a 14.6% decrease in attendances on the WSTHN sites for children under the age of 18. This reduction is likely to be secondary to the increased service provision provided by Merseycare to support young people at home, avoiding crisis admissions to AED. The offer for West Lancashire does not include the provision for 24-hour assessments as in Sefton, resulting in unnecessary admissions while awaiting a mental health assessment.

Table 16: Number of CAMHS Attendances



14. INITIAL HEALTH ASSESSMENTS (IHAs)

14.1. WSTHN site is commissioned to complete the Initial Health Assessments (IHA) for St. Helens children new into care, or children from other boroughs placed in St. Helens. IHAs are a statutory requirement and should be completed within 20 working days of a child entering the care system. The assessments are completed by the Community Paediatricians based on the WSTHN sites.

14.2. During 2023/24 48% of the 172 assessments requested were completed within timeframes, although there were multiple external and internal factors relating to the breaches including late notifications from the LA, children not brought to appointments and issues with appointment allocation secondary to gaps in medical staffing. Meetings are held regularly with the Designated LAC Nurse and the Commissioners to review the process and where possible to reduce breaches.

Table 17: **IHA assessments completed**

Process	Total
Initial Health Assessments –completed when a child is taken into care of the Local Authority.	172
Adult health Assessments – completed to support the recruitment process for foster carers	129
Adoption medicals – completed as part of the adoption process	80

15. PREVENT

15.1. Prevent is part of the Government's counter terrorism strategy, and as the name suggests it is the part of the strategy designed to identify people who may be vulnerable to radicalisation, before they commit any crime. LAs, Health, Education and the Police amongst others form the CHANNEL Panel, which considers every case referred, and determines which professionals should be engaged to intervene in addressing the individual's needs. The Safeguarding Teams attend the relevant Channel panel where those at risk of radicalisation are discussed and share relevant information for those being discussed.

15.2. There remain 2 tiers of training aligned to staff role.

Table 18: Prevent Training Compliance

WSTHN	Q1	Q2	Q3	Q4
PREVENT Level 1 and 2	93.4%	92.7%	91.5%	91.7%
PREVENT Level 3 and 5	87.3%	87.7%	88.7%	90.6%
S&O	Q1	Q2	Q3	Q4
PREVENT Level 1 and 2	90.9%	91.5%	91.3%	93.7%
PREVENT Level 3 and 5	91.2%	91.9%	91.3%	92.1%

15.3. Under the PREVENT agenda there has been 1 referral made from the WSTHN site, this resulted in no further action by the Police, although the case was managed via the Allegations process.

16. MANAGING ALLEGATIONS

16.1. The Assistant Directors Safeguarding and Named Nurses continue to support the Trust with management of allegations. These cases may be allegations in relation to abuse or neglect of a patient, or concerns raised in relation to a staff member and their suitability to work with children and or vulnerable adults; this could include criminal activity, drug and alcohol issues or concerns of abuse to a child or family member.

16.2. All cases are assessed as a matter of urgency via an internal allegation meeting to consider any immediate restrictions that may be required to ensure patient safety; where applicable cases are progressed via the Trust Disciplinary Policy; referrals to relevant governing bodies and DBS reis also considered.

16.3. For WSTHN sites, during this reporting period 49 concerns were raised from Lead Employer, 16 of which required referral to the LADO. From these cases 11 trainees were referred to the DBS and 2 were dismissed from the Trust. In addition, 12 trainees were supported as victims of domestic abuse.

16.4. For WSTHN sites 52 concerns were raised, with 18 referred to LADO. From these cases 3 staff members were redeployed and 11 dismissed from the Trust, 19 referred to the DBS. In addition, 7 staff were supported as victims or domestic abuse.

16.5. For WSTHN 23 cases required safeguarding oversight due to the allegation involving potential harm to patients, where appropriate these cases were referred to the LA.

16.6. For S&O sites 95 potential allegations were reviewed, with 59 requiring an internal safeguarding allegations strategy meeting to undertake immediate actions and inform fact finding required.

16.7. Following the meeting 24 staff had restrictions put in place while the fact finding was undertaken. Referral to the LADO was required for 4 cases, this number is low due to the Southport site only having 16 and 17 years old patients, and therefore the LADO considers the risk to be low, as the staff do not predominantly work with children, or they are not in regulated care. There was Police involvement and or notification to the Police for 4 cases. If the criteria are met a referral will be made to the relevant LA.

16.8. The Safeguarding Teams are represented at all LADO meetings alongside HR colleagues, to offer advice and support with what can be very complex cases requiring extensive investigation.

17. SAFEGUARDING AUDITS

17.1. The Safeguarding Teams have undertaken several audits this year including:

Table 19: Audits undertaken

Audit	WSTHN	S&O
Audit of referrals to Children's Social Care	Although the full 100% compliance was not achieved in any areas, 6 out of the 13 standards did improve from the 2023 audit	This audit offered significant assurance. Further assurance is provided as the Safeguarding Team quality assure all referrals providing additional information to the Local Authority
Child Protection Medical Audit		The assurance level is significant for this audit. There is clear improvement from the original audit and indicates that the recommendations and additional training and discussions of the importance of the process has been beneficial
Paediatric Accident and Emergency (PAED) Documentation Audit		The audit provided full assurance for the safeguarding questions considered in the audit, with all questions achieving 90% - 100%.
Antenatal home visits		This audit relates to the undertaking of one home visit during the ante-natal period. From the cases reviewed 55% had a home visit undertaken showing improvements are required
Completion of safeguarding documentation for children attending the Paediatric Department and identified as being at risk of deliberate self-harm		This audit offered significant assurance; however, further improvements have been noted regarding the risk assessment documentation, and this is included in the work plan
Paediatric Safeguarding Audit: Injuries in children under 12 months of age	Since the initial audit in 2021, there is evidence of improvements in several key areas. Several contributing factors were identified that have supported the improvements	
Routine Domestic Abuse Enquiry during Pregnancy	Compliance with asking routine enquiry of domestic abuse during every antenatal period requires improvement. Improvements have been seen in woman being asked at least once	
Quality of adult referrals audit	100% compliance was achieved in two of the 9 standards. Improvements are required in other aspects of the audits	This audit demonstrates full assurance. Whilst 75% of referrals resulted in safeguarding enquiries being made by the relevant LA, all referrals met criteria for safeguarding as per the Care Act 2014 and reflect the neglect and self-neglect concerns identified at the time the referrals were completed
Completion of MCA and DOLS documentation whole site		The audit offered significant assurance that patients lacking capacity have a completed capacity assessment, and an

		urgent DoLS authorisation completed. Regarding the completion of the daily restrictive practice review, this achieved 100% on 5 of the 11 wards
Safeguarding and MCA knowledge transfer audit		This is audited as part of the Trust then Accreditation Scheme SOCAAS. The knowledge audit is demonstrating staff have an underpinning knowledge of MCA and safeguarding
Restrictive Practice for Patients with an identified Learning Disability and/or Autism		This audit has provided significant assurance. The audit demonstrated that reasonable adjustments had been considered in 95% of cases, with appropriate levels of restriction observed to be in place for all patients reviewed
Management of Domestic Abuse Audit	There is assurance that staff can support victims of domestic abuse through recognition and management. By following the Trust Policy staff ensure appropriate referrals are made, risk is reduced, and victims and children are safe from further harm	
Recording of best interest decisions in relation to medical treatment for patients with a Learning Disability/Autism who lack capacity	Summarised findings from the audit demonstrated that the Mental Capacity Act (MCA) is not embedded into daily practice and improvements are required	
Notification of Mental Health Act Detentions within the Acute Trust	There is no evidence of the adult acute ward's responsibility in the notification of detained patients within their area. However, from the data this is embedded within the paediatric department	

18. EXTERNAL SCRUTINY

18.1. Commissioning Standards

18.2. This year the Trust submitted the Cheshire and Mersey Commissioning Standards. For this reporting year there were two submissions, one to St. Helens Place and one to Sefton Place. However, the Designated Nurses collaborated in their scrutiny, and it is anticipated moving forward there will be one Trust submission.

18.3. The Assistant Directors Safeguarding have developed action plans for each site, as there are some differences with the action's required across the Trust. The action plans are monitored by the Designated Nurses with further evidence submitted with the KPIs quartile submission to St. Helen's Place.

18.4. MIAA Audit

18.5. In December 2023 an audit of safeguarding process across all sites was undertaken by MIAA. The findings were extremely positive with an overall rating of substantial assurance, with some areas of high assurance, as detailed below. An action plan has been developed to address the medium and low risk recommendations.

Table 20: MIAA Audit Result

Objectives Reviewed	RAG Rating
Strategy	High
Policies and procedures	Substantial
Governance arrangements	High
Staff roles and responsibilities	Substantial
Training	Substantial
Multi agency working	High
Overall Rating	**Substantial**

18.6. Section 11 Scrutiny

For WSTHN sites the annual section 11 audit was submitted to St Helens LSCP and a site visit from Board Members was undertaken, as offer of additional scrutiny. Positive feedback was received with compliance achieved in all areas. For S&O sites the S11 audit is only completed bi-annually to Lancashire CSAP.

19. RISK REGISTER

19.1. There are 3 risks relating to safeguarding in 2023/24:

19.2. There is no MHA Administration SLA in place for the WSTHN sites, which places the Trust at risk of lack of compliance with the Mental health Act and detaining patients unlawfully. The administration currently lies with the Safeguarding Practitioners who do not have the relevant training to complete this process.

19.3. For the S&O sites Lancashire Local Authority is not undertaking Best Interest Assessments; therefore, the Trust may be depriving patients of their liberty without the necessary legislation in place. This has been escalated via the Lancashire Safeguarding Board, and the Local Authority has a process for prioritising their waiting list. This has been mitigated as detailed in risk register.

19.4. The S&O sites do not have a clinical photography team; as a result, photographs provided by the Trust for the purpose of child protection and criminal investigation processes and wound or pressure ulcer management do not represent the injury/harm/wound/pressure ulcer accurately. After the Assistant Director of Safeguarding and colleagues from the Division presented a business case to the Executive Team, expanding the service to S&O site is recognised as a cost pressure and will be considered as MWL.

20. THE SAFEGUARDING TEAM's WORK PLAN 2024/2025

- We will develop ways of working to enable the submission of a MWL KPI submission to St. Helens Place
- We will continue to align policies and processes and documentation
- We will work review the governance of safeguarding reporting
- We will work to develop an MWL annual report
- We will complete the ICB Safeguarding Commissioning Standards in Q3 and develop relevant action plans
- We will deliver the action plan of the MIAA Audit
- We will extend the Mental Health Administration SLA across all sites
- We will review and were possible harmonise the audit plans across sites
- We will harmonise the Training Needs Analysis for all safeguarding training
- We will collaborate with the digital team to develop digital and new ways of working
- We will collaborate with BI colleagues to enhance safeguarding reporting and monitoring
- We will update the daily restrictive practice form in accordance with ADASS recommendations
- We will revise MCA documentation to align to the most current case law
- We will support the implementation of the new children's Social Care referral process in Sefton, and other improvements within the Local Authorities
- We will support the implementation of the new MARAC process in Lancashire, and other improvements within the Local Authorities

21. CONCLUSION

21.1. Progress continues in the journey towards safeguarding being embedded in to practice and considered everyone's business. The team work operationally within the Trust and engage extensively with external partners, given the nature of safeguarding being a multi-agency and multi-professional practice.

21.2. The Safeguarding Team oversee and monitor key areas to ensure appropriate referrals and actions are undertaken to safeguard the un-born, children, young people, and adults at risk of abuse. This has been enhanced by the additional roles of the LDAP, the HIDVAs and the HISVA. The Safeguarding Team will continue to improve and simplify processes, embed training into practice, ensuring quality referrals are undertaken, and enable staff to use their time with patients effectively to identify and manage safeguarding concerns.

21.3. The Safeguarding Teams on all sites have continued to demonstrate a high volume of activity in relation to Safeguarding Adults, Children and Unborn infants. This provides significant assurance that safeguarding continues as a priority across the organisation. There is evidence of commitment to multi-agency working demonstrated by the number of referrals into partner organisations and multi-agency meetings attended. Compliance with guidance and legislation can demonstrated with the increase in the

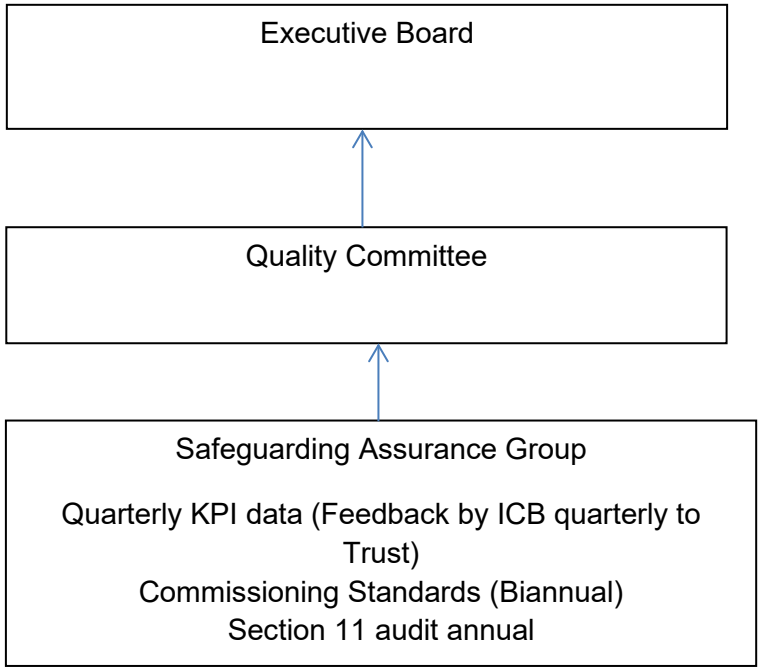
number of DoLS, domestic abuse risk assessments and referrals, and through the management of allegations against staff.

21.4. The teams have worked together to commence reviewing and harmonising safeguarding polices and processes, including the KPI reporting process. Training compliance has improved although there is still improvement required to achieve 90% in all areas. There evidence of positive feedback from external scrutiny including the
21.5. Section 11 and MIAA Audit with minimal recommendations and actions required.

22. RECOMMENDATIONS

22.1. The Committee is asked to recognise the achievements made by the Safeguarding Team this reporting period outlined in the report and agree the work plan for the year ahead.

Appendix 1: Governance Arrangements



Appendix 2: Trust Safeguarding Structure