**Meeting of the Board of Directors**
**HELD IN PUBLIC**
**Friday 5 May 2017 at Liverpool Women's Hospital at 1000**
**Board Room**

| Item no.<br><br>2017/ | Title of item | Objectives/desired outcome | Process | Item presenter | Time | CQC Fundamental Standard | BAF Risk |
|---|---|---|---|---|---|---|---|
| | Thank you to Staff | | | | 1000 | | |
| 113 | Patient Story | | | | 1005 (20mins) | | |
| 114 | Apologies for absence & Declarations of interest | Receive apologies | Verbal | Chair | 1025 (10mins) | - | - |
| 115 | Meeting guidance notes | To receive the meeting attendees' guidance notes | Written guidance | Chair | | R17 – Good Governance | - |
| 116 | Minutes of the previous meetings held on 7 April 2017 | Confirm as an accurate record the minutes of the previous meetings | Written | Chair | | R17 – Good Governance | - |
| 117 | Action Log and matters arising | Provide an update in respect of on-going and outstanding items to ensure progress | Written/verbal | Chair | | R17 – Good Governance | - |
| 118 | Chair's announcements | Announce items of significance not elsewhere on the agenda | Verbal | Chair | 1035 (5mins) | R17 – Good Governance | All |
| 119 | Chief Executive Report | Report key developments and announce items of significance not elsewhere | written | Chief Executive | 1040 (10mins) | R17 – Good Governance | All |
| BOARD ASSURANCE | | | | | | | |
| 120 | Chair's Report from the Finance Performance and Business Development Committee | Receive assurance and any escalated risks | Written | Committee Chair | 1050 (10mins) | R17 – Good Governance | 5 a - f |

| Item no.<br><br>2017/ | Title of item | Objectives/desired outcome | Process | Item presenter | Time | CQC Fundamental Standard | BAF Risk |
|---|---|---|---|---|---|---|---|
| 121 | Chair's Report from the Putting People First Committee | Receive assurance and any escalated risks | Written | Committee Chair | | R17 – Good Governance | 1 & 3<br>5 a - f |
| 122 | Mortality Strategies | To approve the adult mortality and Stillbirths and Neonatal strategies | Paper/ Presentation | Medical Director | 1100 (30mins) | All | All |
| 123 | Junior Doctors Guardian for Safe working | Receive assurance and note future requirements | Written | | 1130 (5mins) | | |
| TRUST PERFORMANCE | | | | | | | |
| 124 | Performance Report period 12, 2016/17 | Review the latest Trust performance report and receive assurance | Written | Director of Operations | 1135 (10mins) | R12&18: Safe<br>R17 – Good Governance | 3a |
| 125 | Finance Report period 12, 2016/17 | To note the current status of the Trusts financial position | Written | Director of Finance | 1145 (10mins) | R17 – Good Governance | 5a-f |
| TRUST STRATEGY | | | | | | | |
| 126 | Trust Operational Plan 2017-19 | To note the Operational Plan 2017-19 | Written | Chief Executive/ Director of Finance | 1155 (10mins) | All | All |
| 127 | Corporate Objectives 2017-18 | To approve | Written | Chief Executive | | All | All |
| 128 | Fit for Future Generations Update | To brief the Board on progress and risks | Verbal | Chief Executive | | All | All |
| BOARD GOVERNANCE | | | | | | | |
| 129 | Review of risk impacts of items discussed | Identify any new risk impacts | Verbal | Chair | | R17 – Good Governance | All |
| HOUSEKEEPING | | | | | | | |
| 130 | Any other business & Review of meeting | Consider any urgent items of other business | Verbal | Chair | 1205 End | - | - |

Date, time and place of next meeting Friday 2 June 2017

## Meeting to end at 1205

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| 1205-1220 | Questions raised by members of the public observing the meeting on matters raised at the meeting. | To respond to members of the public on matters of clarification and understanding. | Verbal | Chair |

Board Agenda item 17/116

# Board of Directors

Minutes of the meeting of the Board of Directors
held public on Friday 7 April 2017 at 0900 hrs
in the Boardroom, Liverpool Women's Hospital, Crown Street

PRESENT

| | |
|---|---|
| Mr Ian Haythornthwaite | Acting Chair (Non-Executive Director/Vice Chair) |
| Mrs Vanessa Harris | Acting Chief Executive & Director of Finance |
| Mr Tony Okotie | Non-Executive Director/SID |
| Mr Ian Knight | Non-Executive Director |
| Dr Susan Milner | Non-Executive Director |
| Mr David Astley | Non-Executive Director |
| Mrs Michelle Turner | Director of Workforce & Marketing |
| Dr Andrew Loughney | Medical Director |
| Mr Jeff Johnston | Director of Operations |
| Mr Doug Charlton | Director of Nursing & Midwifery |
| Mrs Jenny Hannon | Acting Director of Finance |

IN ATTENDANCE

| | |
|---|---|
| Mr Colin Reid | Trust Secretary |
| Mrs Julie King | Deputy Director of Nursing & Midwifery |

APOLOGIES

| | |
|---|---|
| Mr Robert Clarke | Chair |
| Ms Jo Moore | Non-Executive Director |
| Mrs Kathryn Thomson | Chief Executive |
| Mr Phil Huggon | Non-Executive Director |

**Thank You**

Thank you was made to the Derek Parkinson, Consultant Gynaecologist on his retirement from the Trust. The Board expressed their appreciation.

079 **Apologies** – as above.

**Declaration of Interests** – None

080 **Meeting guidance notes**
The Board noted the meeting guidance notes.

081 **Minutes of previous meeting held on Friday 3 March 2017**
The minutes of the meeting held on 3 March 2017 were approved.

082 **Matters arising and action log.**
The Board noted that all actions were either complete, on the agenda or to be reported at a future meeting. Recognition was given to the date changes to conclude the actions.

078 Patient Opinions

Michelle Morgan – Head of Audit, Effectiveness & Experience and Kevin Robinson – Deputy Head of Patient Experience provided a presentation on 'Patient Opinion' the UK's leading independent non-profit feedback platform for health services. The Head of Audit, Effectiveness & Experience explained that the platform was about honest and meaningful conversations between patients and health service providers.

The Head of Audit, Effectiveness & Experience and Deputy Head of Patient Experience explained the importance of the platform and positive impact the platform provides both for patients and staff.

Tony Okotie referred to the use of the Patient Opinion platform and asked how it was managed in the Trust. In response the Head of Audit, Effectiveness & Experience advised that a link is provided from the Trust Website and posters and leaflets were being produced to signpost patients to use the platform.

The Head of Audit, Effectiveness & Experience reported that the Experience Senate receives reports taken from the website to obtain themes and action lessons learned.

The Acting Chair thanked the Head of Audit, Effectiveness & Experience and Deputy Head of Patient Experience for the presentation which was supported by the Board.

083 Chair's Announcements

CIP and Finance Board and Governor Workshop: The Acting Chair reported on the Governor and Board session which gave opportunity to discuss and gain a deeper understanding of the financial and operational plans of the Trust. The Acting Chair thanked those directors who supported the meeting.

Governor Patient Experience and Membership Engagement Committee: The Acting Chair thanked the Non-Executive Directors that attended the Governors Patient Experience and Membership Engagement Committee which discussed the building of relationships between Governors and the Non-Executive Directors and Board. He reported that the Committee discussed opportunities for interaction which included ideas to formalise the sometimes ad-hoc Council workshop sessions into a Council committee structure which when supported by Executive and Non-Executive Directors would provide additional opportunities for Governors and Directors to interact in a more 'working' environment; would reduce the workload of the formal council meetings; and assist in the Governors role of receiving assurance from the Trust and of the Governors role in holding to account the Non-Executive Directors.

Governor Quality indicator workshop: The Acting Chair reported on the Governor Quality indicator workshop which was held in March that was supported by the Trust Secretary, Medical Director and Head of Governance. He advised that there was good discussion surrounding the selection of the quality indicator for external audit and reported that the Governors had chosen on advice from the Medical Director the indicator "To reduce the incidence of stillbirths attributed to Small for Gestational Age (SGA) by 20%".

Baroness Cumberledge: The Acting Chair advised on the visit from Baroness Cumberledge who had attended the Trust to see how the Trust was progressing on with being a pioneer site for Better Births. He reported that there had been positive feedback from her meeting with our midwifery teams.

Steve Rotherham MP: The Acting Chair advised on the visit of Steve Rotherham MP who attended the Trust to meet Consultants, Doctors, Midwives and Nurses to better understand the issues facing the Trust both financially and clinically. Steve Rotherham MP visited Neonatal service and the Delivery

Suite.

The Acting Chair advised that the Chair had attended a meeting of the Federation of Specialist Hospitals at the invitation of the Federation. He reported that the Chair found the meeting enlightening and wanted to consider whether the Trust may find being a member of the Federation of interest. The Chair also attended with the Medical Director and Susan Milner a seminar on the National guidelines on Learning from Deaths hosted by NHS England and NHS Improvement. The Acting Chair explained that the seminar set out the responsibilities of Directors regarding mortality. The Board noted that a workshop session had been identified for the 5 May Board meeting for the Board to discuss mortality strategy.

The Board noted the acting Chair's update report.

084 Chief Executive's report

The Acting Chief Executive presented her Report and highlighted a number of matters contained within it.

Referring to the Care Quality Commission meeting with the Chief Executive and senior managers on Monday 20th March, the Acting Chief Executive reported that the meeting went well and that the Trust had provided action plans to address the recent Never Events and Serious Incidents. Regarding the anonymous concerns, the acting Chief Executive advised that the CQC were assured that the Trust had a positive and supportive culture of risk reporting and the 'Board to ward' escalation and feedback was well established and effective.

The Acting Chief Executive reminded the Board of the 2017 Dedicated to Excellence Awards that was due to take place on Thursday, 13th April 2017, at the Marriott Hotel.

The Acting Chief Executive drew the Board attention to the NHS England Mandate 2017-18 published on 20 March 2017. She explained that the mandate sets the government's objectives for NHS England, as well as its budget. In doing so, the mandate sets direction for the NHS and seeks to ensure that the NHS was accountable to parliament and the public.

The Board noted the Report from the Acting Chief Executive.

085 Annual Staff Survey 2016

The Director of Workforce and Marketing presented the findings of the Annual Staff Survey 2016 and reported that as a Board, it had the responsibility, as articulated in the CQC Well Led key lines of inquiry to shape an open, transparent and quality focused culture. She went on to explain that the Staff Survey was a national tool to measure staff engagement and wellbeing in NHS.

The Director of Workforce and Marketing made a number of observations regarding the Survey:

- The Trust surveys its entire workforce and traditionally had a high response rate. This year, although slightly lower than last year, at 60%, it was still significantly higher than the national average response rate of 44%;
- Overall no statistically significant change to results compared to 2015 other than a slight deterioration in staff motivation;
- The Trust continues to be grouped with acute specialist organisations and is benchmarked against these organisations that have traditionally the highest levels of staff engagement. Many of the Trust services were more akin to acute organisations so the Trust also compares itself to those organisations;
- The Trust anticipated a challenging year in Staff Survey terms particularly given the continuing financial challenge, the uncertainty regarding the organisational future and the general feeling in the wider NHS. The requirement for 'grip and control' across the entire

NHS had led to some leaders feeling a loss of autonomy and influence.

- Significant engagement was undertaken with staff in the development of the Future Generations Strategy and whilst staff were clear about the clinical case for change, the complexity of the NHS processes the Trust found itself working through to deliver the Strategy had potentially left staff with a level of uncertainty and even apathy. The Trust had seen increases in staff turnover, particularly in corporate services which was reflective of the uncertainty staff in these areas surrounding the national drive to reduce and share back office costs across organisations.

The Director of Workforce and Marketing reported that in line with previous years, nurses and midwives respond consistently more negatively to the survey than other groups of staff and advised that this was a national feature of the survey. Referring to the Trust's People Strategy the Director of Workforce and Marketing advised that it was in its second iteration, with one of the key measures of progress being the 'Recommendation of LWH as a place to work or come for treatment'. The Director of Workforce and Marketing advised that whilst the Trust had seen a slight drop in this key metric this year, the overall trend over the last five years was an improving one. Leadership Development and supporting staff to develop both professionally and personally was a key underpinning principle of the Trust's people strategy; the Director of Workforce and Marketing explained that whilst the Trust had a comprehensive and high quality, modular leadership programme, attendance had been poor with operational managers citing pressures in the service as reasons for non-attendance by staff. This issue had been identified and discussed at the Putting People First Committee and plans had been put in place to ensure release and attendance for key post holders to the programme.

The Director of Workforce and Marketing reported on the Trust's values which had been longstanding and had been developed in partnership with staff and patients and had been regularly tested to ensure they were still appropriate and support the delivery of the Trust's vision to be the leading provider of healthcare for women, babies and their families. The Director of Workforce and Marketing advised that it has been recognised that often when an organisation and staff were under pressure the first thing to be tested was behaviours of staff towards each other and advised that work needed to be done in the organisation at every level to ensure that staff were confident to challenge inappropriate behaviours and understand the consequence of poor behaviour.

The Director of Workforce and Marketing advised that the paper outlines the actions being taken not only in response to the feedback from the Staff Survey but as part of our commitment to the longer term People Strategy. She went on to explain that the systematic and incremental approach adopted to date had delivered significant improvements in overall staff engagement over the last five years and it was important that the Trust maintained both drive and focus on staff experience and involvement at every level.

The Director of Workforce and Marketing asked the Board to consider the feedback from the survey and the actions outlined in the paper noting that the Putting People First Strategy and its annual objectives were regularly reviewed through the Putting People First Committee.

The Acting Chair welcomed the feedback from the survey and commented on the challenge the Trust faced in improving staff wellbeing and morale. He referred in particular to the corporate areas which had seen higher turnover of staff and increase pressures resulting in increased sickness absenteeism and asked what was being done to address these areas. The Director of Workforce and Marketing advised that action were underway to address the corporate areas and advised that the area was out of step with the rest of the Trust. The Acting Chair asked that the PPF Committee garner assurance that these areas were being looked at on behalf of the Board.

The Board discussed the feedback from the survey and the actions being undertaken to address

concerns. The Board considered the importance of improved targeted communications to those areas that may not receive messages from the Board. The Director of Nursing and Midwifery recognised the importance of key messages being filtered in the most effective way from Board to Ward so that all staff were aware of the key messages and did not feel disenfranchised impacting on morale. The Medical Director was pleased to see the higher number of respondents from the medical staff, however this was impacted by the lower number of respondents from midwifery and felt that this required further investigation.

The Board noted the contents of the report and supported for the actions proposed. The Board further noted that the staff survey results provided the driver and opportunity to re-invigorate the Trust's commitment to supporting and developing its staff and ensuring that the objectives set out in the Putting People First Strategy were achieved.

The Board noted that the Putting People First Committee would address the themes raised in the staff survey.

086 Chair's Report from the Governance and Clinical Assurance Committee (GACA)

Susan Milner presented the GACA Chairs report which was noted. Susan Milner highlighted the key work of the Committee in particular referring the Board to concerns expressed surrounding medical management and advised that the Committee had raised this concern due to the potential delay in providing assurance papers relating to specific medicines management response to the CQC Fundamental Standards and self-medication administration. Susan Milner advised that the concerns had been escalated to the Chief Executive and Executive team to address.

Referring to the Clinical Audit Work Programme 2017-18, Susan Milner advised that the Committee had approved the programme of work and had noted that due to the extent of the programme that it would be conducted on a risk assessment basis.

The Acting Chair thanked Susan Milner for her report which was noted.

087 Chair's Report from the Audit Committee

Ian Knight Chair of the Audit Committee ran through the content of the Chair report.

Referring to the matters to highlight to the Board, Ian Knight reported on the Change of Internal Auditor and Counter Fraud service from 1 April 2017, with the appointment of Mersey Internal Audit in the place of RSM. He reported that the Committee had been assured that processes were in place to support a clean hand over of work. With regard to the External Audit, Ian Knight advised that the Committee had been informed that, as with last year, the external audit opinion would include an 'Emphasis of Matter' due to the Trust's financial position.

Referring to the work of the internal auditor for 2016/17, the Committee had received the internal auditor opinion which stated that "The Trust had adequate and effective framework for risk management, governance and internal control"; however, the internal auditors work had identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective. Ian Knight advised that the statement would be included in the Annual Governance Statement in the Annual Report & Accounts 2016/17 with a response from the Trust.

The Acting Chair thanked Ian Knight for his report which was noted.

088 Chair's Report from the Finance Performance and Business Development Committee (FPBD)

The Acting Chair reported on the work of the FPBD Committee which was noted. He advised on the challenging CIP programme for 2017/18 which was required to be delivered in order to deliver the

agreed control total.

089 **Board Committees Terms of Reference**

The Trust Secretary presented the agreed amendments to the terms of reference of the Board committees which were approved. The Acting Director of Finance commented on the FPBD terms of reference that required slight amendment to one of its duties regarding the approval of NHS Improvement Quarterly returns. She advised that changes had been made in the submissions required by NHS Improvement and this particular duty required updating to take account of the changes. With regards to GACA terms of reference the Director of Operations asked that he is added to the membership of the Committee.

The Board considered the amendments included in the paper and those identified in discussion and approved the amendments.

090 **Quarterly Serious Incidents Report**

The Medical Director presented the Quarterly Serious Incidents Report and explained that the report was still in development stage and future reports would include additional reporting on lesson learned from the incidents and how the lessons learned would be embedded within the services and were appropriate across the Trust. He felt this would provide the Board with the assurance it needs that the Trust was learning from incidents. The Medical Director advised that prior to coming to the Board, GACA received a quarterly report on serious incidents and this had been reported in the GACA Chair Report earlier in the meeting.

The Board considered the action plans of serious incident reported in the paper that were overdue and directed the Medical Director to review why they continued to remain overdue. The Medical Director reported that in most cases the action plans were overdue, due to external factors that influenced the closure of the actions. He referenced SI 2016/1835 - MDT groups and operating teams ensure and document review and consideration of all relevant pre-surgical investigations. The Acting Chief Executive recognised the problems arising from external factors; however CQC's expectations would be that standards must continue to be met and therefore it was imperative that action plans were closed down. If specific actions were not possible to close, due to outside influences then they should be identified and mitigated as much as possible. She asked that for the next iteration of the Report, additional information on the risks should be identified. Tony Okotie asked whether these additional risks were included on the Corporate Risk Register and asked whether it would be appropriate for GACA consider this at their next meeting. Susan Milner agreed that this would be a matter for GACA to consider together with how they were reviewed in the future taking account of the comments of Tony Okotie in recognising what the size of the problem was, what the risks where and what mitigations were in place to address the risk.

*Action 2017/090: The Medical Director to provide an update to the GACA meeting in May 2017 on the closure of the overdue action plans taking into account the Board discussion.*

The Board noted the Quarterly Serious Incident Report and asked that GACA when reviewing future reports it takes into account the Board discussion.

091 **Mortality Strategies**

The Medical Director presented his paper which set out the process for the approval of the Trust Adult Mortality Strategy and Still Births and Neonatal Strategy.

The Medical Director provided the Board with an insight into future reporting to the Board which would be undertaken on a quarterly basis following approval of the Strategies and referred to the section in the strategy on how this would be done. The Board discussed the strategies noting that it would be asked to approve the two strategies at the 5 May 2017 Board meeting together with a short

presentation on the main aspects of the strategies.

The Acting Chair thanked the Medical Director for his update noting that the matter had also been discussed at length at the March GACA Committee meeting.

092 Quality, Operational Performance Report Period 11 2016/17

The Director of Operations presented the Quality, Operational Performance Report Period 11 2016/17 and reported that of the thirty three KPI's RAG rated in the Trust Board Dashboard for February 2017, twenty three were rated Green, six were rated Red and three rated as Amber. The Director of Operations advised that all of the NHS Improvement mandatory indicators were green and on target to deliver at the end of the financial year.

The Director of Operations commented that overall February 2017 performance had improved in comparison to the previous month; however, most of the KPI's where the targets had not been achieved had been prevalent throughout the year. These included the HR KPIs along with Maternity Triage and Diagnostic Waits. The Director of Operations advised that it was his view that overall performance would continue to improve when reporting the position at the year end, although some of the local KPI's that the Trust had failed to achieve throughout the year would continue to be of concern come the end of the financial year.

The Board noted that the report and indicators had been discussed at FPBD, GACA and also at PPF and that no exceptional reporting had been made by the Chair of each committee.

093 Financial Report & Dashboard Period 11 2016/17

The Acting Director of Finance presented the Finance Report and financial dashboard for month 11, 2016/17 and reported that Trust was reporting a monthly deficit of £0.59m against a deficit plan of £0.71m which was a positive variance of £0.12m for the month. Cumulatively the Trust was slightly ahead of plan by £0.32m on a year to date budget of £6.5m deficit and delivering a Use of Resources Rating of 3 which was equivalent to plan.

The Acting Director of Finance advised that as reported earlier the Trust was on track to deliver the overall 2016/17 control total.

The Acting Chair thanked the Acting Director of Finance for her report which was noted.

094 Fit for Future Generations Update

The Acting Chief Executive advised that the Executive team were continuing to work with Liverpool CCG, NHS Improvement and NHS England to move the process forward to public consultation. There was recognition that public consultation would not proceed until NHS England decides on when this would happen.

The Board discussed the need to develop a communication plan that covered the business as usual period of operation of the Trust. It felt that important messages regarding the estate redesign were not fully understood both within the Trust and externally. Reference was made to the estate work currently being undertaken in Gynaecology service and Outpatients which was to provide improvements for patients and at the same time improve efficiencies and provide cost savings.

The Board noted that both projects were great steps forward in terms of efficiencies and patient experience; however they did not reduce the clinical risks identified in future generations and PCBC. The Board felt that it was important that as the Trust communicated better with both staff and the public on why the Trust was continuing to spend money on the Crown Street site to make improvements for patients whilst it remained at Crown Street.

The Director of Workforce and Marketing agreed to produce a fit for future generations' communications for staff.

*Action 2017/094: The Director of Workforce and Marketing agreed to produce a fit for future generations' communications for staff.*

095 **Review of risk impacts of items discussed**

The Board noted the risks had been discussed during the meeting.

096 **Any other business & Review of meeting**

None.

Conduct of the meeting was very good with good challenge, scrutiny and assurance provided. The Chair felt that there was contribution from all members of the Board.

**Date and time of next meeting**

5 May 017

TRUST BOARD
May 2017 Action Plan

| Meeting date | Minute Reference | Action | Responsibility | Target Dates | Status |
|---|---|---|---|---|---|
| 7 April 2017 | 2017/094 | The Director of Workforce and Marketing agreed to produce a fit for future generations' communications for staff. | Director of Workforce and Marketing | Complete – 18 April 2017 | See agenda item 119 (5 May 2017) |
| 7 April 2017 | 2017/090 | The Medical Director to provide an update to the GACA meeting in May 2017 on the closure of the overdue action plans taking into account the Board discussion. | Medical Director | On target – 15 May 2017 | On target to be reported at GACA at its meeting on 15 May 2017 |
| 3 March 2017 | 2017/58(i) | The Medical Director to provide training on mortality at the May 2017 Board meeting. | Medical Director | Complete | On the Board agenda item 2017/117 (5 May 2017) |
| 4 Nov 2016 | 2016/278 | Director of Nursing and Midwifery to provide an update to the board on progress made against the action plan regarding the implementation of the National Maternity Review in February 2017. | Director of Nursing and Midwifery | 7 July 2017 | 3 March 2017 Update: An update presentation was be provided to the Board on 3 February 2017 with a formal paper presented to the Board at the 7 July 2017 meeting following the visit from Baroness Cumberlege<br><br>Action ongoing. |
| 7 Oct 2016 | 2016/255 | The Executive Team to review the risks identified in the BAF and bring back a proposal on whether the risks can be grouped or consolidated. | Trust Secretary/Executive | (i) 7 April 2017 - complete<br>(ii) 5 May 2017 | 3 February 2017 update: This action has now been superseded following the findings of the CQC mock inspection reported through GACA. A complete review of the BAF has been commissioned that would take into account not only the consolidation of the risks on the BAF (these have continued to be reviewed by the Committees) but also to consider structural changes to the way the BAF reports and manages the risks and its relationship with the Corporate Risk Register. The Executive with the support of the Chair has commissioned an external review of the BAF to make it fit for purpose and accessible by the Board, Board committees and staff. |

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| | | | | | 3 March 2017 Update: a Board workshop on the day of the April Board has been arranged to review the structure of the new BAF and risks following which the final version of the BAF will be circulated prior to being received at the 5 May 2017 meeting,<br>7th April 2017 Update: Board workshop to discuss BAF following the Private Board on 7 April 2017<br>Action ongoing. |

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| **Agenda item no:** | 2017/119 |

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| **Meeting:** | Board of Directors |

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|---|---|
| **Date:** | 5 May 2017 |

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| **Title:** | Chief Executive's Report |

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| **Report to be considered in public or private?** | Public |

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| **Where else has this report been considered and when?** | N/A |

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| **Reference/s:** | N/A |

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| **Resource impact:** | - |

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| **What is this report for?** | **Information** | ✓ | **Decision** | | **Escalation** | | **Assurance** | ✓ |

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| **Which Board Assurance Framework risk/s does this report relate to?** | **All** |

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| **Which CQC fundamental standard/s does this report relate to?** | **Reg 17: good Governance** |

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| **What action is required at this meeting?** | To receive and note the report. |

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| **Presented by:** | Kathryn Thomson, Chief Executive |

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| **Prepared by:** | Colin Reid, Trust Secretary |

This report covers (tick all that apply):

| **Strategic objectives:** | |
|---|---|
| To develop a well led, capable motivated and entrepreneurial workforce | ✓ |
| To be ambitious and efficient and make best use of available resources | ✓ |
| To deliver safe services | ✓ |
| To participate in high quality research in order to deliver the most effective outcomes | ✓ |
| To deliver the best possible experience for patients and staff | ✓ |

| **Other:** | | | |
|---|---|---|---|
| Monitor compliance | ✓ | Equality and diversity | |
| Operational plan | | NHS constitution | |

| **Publication of this report** (tick one)**:** | |
|---|---|
| This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting | ✓ |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedom of Information Act 2000, because such disclosure might constitute a breach of confidence | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust | |

In this briefing for the Board I aim to summarise recent and relevant information which relates to:

Firstly, in **Section A**, news and developments within the Trust itself that is not already reported elsewhere.
Secondly, in **Section B**, news and developments within the immediate health and social care economy.
Thirdly, in **Section C**, other news and developments within the wider national health and social care economy, including regulatory developments.

Further information is available on request on any of the topics covered by the report.

Kathy Thomson.
**Chief Executive.**

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## SECTION A - INTERNAL

**Staff Briefing :** Fit for future generations - plans for 2017/18. The attached staff briefing went out to all staff on 18 April 2017.

**Dedicated to Excellence:** It was a fantastic night, enjoyed by many staff across the Trust. Leanna Campbell, host of the Radio City Breakfast Show was our compare again and did a brilliant job announcing all the winners and entertaining the crowd. We were also joined by the Livertones who had everyone dancing the night away! There were some great highlights of the night, one being *Ed Djabatey,* Consultant Anaesthetist, who was awarded the Outstanding Contribution Award and *Marie Mace* who was awarded Employee of the Year after being nominated via Facebook and our *Team of the Year Neonates*!

**Winners:**

Innovation and Improvement (Non-Clinical) : *This is how we do it - Scientific Admin Style*
Innovation and Improvement (Clinical): *All about that Base*
Dedicated to Patient Safety: *H.I.P Hep Hooray!*
Dedicated to Patients and their Families: *I Can't Hear You!*
Dedicated to Research : *Amy Barrie PhD project: Embryo Time Lapse Imaging Algorithms*
Dedicated to Working Together (Team Working and Partnerships) : *Team Theatre*
Employee of the Year : *Marie Mace – Reception*
Mentor of the Year: *Jennifer Long - Community Placement in Sycamore South*
Learner of the Year: *Emergency - How can I Help - Cheryl McNamara, Jenny Robinson & Famida Siddiq-Ahmed*
Team of the Year : *Neonatal Unit*
Volunteer of the Year: *Annalyn Lim - Meet and Greet*
Patient Choice Award: *Gynae Ward 2*
The Foundation Award : *Sharper Waste Reduced Cost*
Chief Executive Outstanding Contribution Award : *Ed Djabatey*

**Employee of the Month Winners**: Congratulations to our Employee of the Month Winners, Louise Jackson (Midwife) and Sam Willis (Recovery Nurse). Louise was nominated by one of our patients who said she is a wonderful, caring and compassionate Midwife. Sam was nominated by a colleague. Sam was instrumental in assisting a patient who was rushed back to Theatre for emergency surgery. She stayed late after her shift and kept the family updated

**Dame Lorna Muirhead:** Dame Lorna Muirhead has informed the trust that she is stepping down from Lord Lieutenancy and will therefore stepping down as patron of Trust. I would like to personally thank Dame Muirhead for her support of the Trust.

SECTION C – NATIONAL

Pay Award 2017: The Government has accepted the recommendations from the NHS Pay Review Body and the Review Body for Doctors' and Dentists' Remuneration, and a 1% consolidated pay increase will be paid to all NHS staff, both those on Agenda for Change terms and conditions of service and medical staff, effective from 1st April 2017.

Review identifies £10bn capital funding gap: The review of NHS property and estates by Sir Robert Naylor last week published its findings. It concludes that £10bn additional capital will be needed to clear the maintenance backlog and support the sustainability and transformation plan (STP) process. It also calls for the creation of a powerful new NHS Property Board to provide leadership, expertise and delivery support to trusts and STPs. NHS Providers chief executive Chris Hopson said the review confirms longstanding trust concerns of a large and growing gap in capital funding. He said: "It concludes that at least £10bn will be needed to tackle the maintenance backlog and to deliver the requirements of the NHS Five year forward view. Both are vital if trusts are to continue providing the right quality of care for patients." Chris said the recommendations are measured, sensible and helpful responses to the challenge of how best to harness the value of the NHS estate, and that a new NHS Property Board will be beneficial to our members as long as it is effectively resourced and acts on the basis that its role is to help and serve the NHS frontline.

Liverpool Women's NHS Foundation Trust

Dedicated to you

# Staff Briefing

## Fit for future generations - plans for 2017/18

**2016/17 was another year full of both great achievements and significant challenges for Liverpool Women's. As always the quality of care provided to our patients was second to none, but we have all had to work hard to address our financial and operational challenges, which are likely to continue to be issues for the foreseeable future.**

You told us at a recent *In the Loop* briefing that you wanted more detail and information on the Trust's current position and what the plans are for the future. Hopefully the information below will help you understand where we are at currently and will help you explain to patients, their families and others if you are asked any questions about the hospital's future.

### Public Consultation

The long term future of our services is still to be determined You will recall that four options for the future were identified: (1) Relocate to a new building next to the new Royal Liverpool Hospital (2) Relocate to a new building on the Alder Hey site (3) Remain at Crown St with major improvements (4) Remain at Crown St with smaller improvements.

Here at Liverpool Women's we have been clear for some time about our preferred option – to relocate adjacent to the new Royal Liverpool Hospital.

However, a public consultation led by Liverpool CCG will need to take place before any final decision can be made about the future of this hospital and its services. The CCG will not get approval to run that public consultation until NHS England are assured that there are robust plans to finance the new building.

You may have thought things have gone a little quiet but this is because of local mayoral elections, which means any further public conversations about the future of our services have to wait until after 4th May. However, we are working closely with our CCG, NHS England and other colleagues to identify potential funding solutions and responses to NHS England's questions.

It is important to remember, however, that even when approved any changes will take a long time to implement (a relocation to a new hospital building could take anywhere between 5 – 10 years).

We cannot stand still during this time. Our *Future Generations* strategy identified some clinical issues that need to be addressed as best we can in the short term. It is for this reason that you will see us continuing to invest in services here at Liverpool Women's.

### Keeping our services fit for the future

We understand that whilst the future of the Trust's services is unclear, staff and the public may question why we are spending money on a hospital site that we may move from in the not too distant future.

As already mentioned, regardless of the outcome of any decisions, Liverpool Women's will be located at its current site for a number of years to come. Therefore investment and refurbishment of the current site is required to meet patient needs now. Two of the main projects currently taking place are; the Gynaecology Unit Refurbishment, and the Outpatients Facilities Improvement Programme.

*Gynaecology Unit Refurbishment*

We are upgrading our two existing Gynaecology Wards to make a new Gynaecology Unit. The main aim of the project is to ensure that we look after patients at the right time, in the right place and with the right clinical teams around them.

Work is well underway now to remodel and modernise our Gynaecology Unit, making for a better patient experience by providing more up to date facilities, as well as a more efficient clinical space for our staff to work across.

The new Gynaecology Unit (due to be completed by early summer) will provide a more modern, bright and easily accessible area which will include a new admission lounge, new consulting rooms, new patient changing facilities, and revised bed space. A huge thank you to all our Gynaecology staff who are working hard to ensure minimal disruption to patients and their families.

*Outpatients Facilities Improvement Programme*

We are also redeveloping our Outpatients facilities with a new layout, improved amenities, and an interactive appointment check-in and reminder system that will provide a better experience for our patients. This means we will have;

- A patient appointment self check-in system
- A centralised reception area for ease of access for patients attending any outpatient appointment at Liverpool Women's
- A redesigned centralised outpatient area which provides better facilities for patients An advanced patient call handling system with an integrated appointment reminder system consisting of text, email, and automated call messaging.

The introduction of the new self check-in is scheduled for June 2017. The redevelopment of the Outpatients environment started in April, with completion expected early June 2017.

Another huge thank you to our Outpatient, administration and Volunteer staff who are all working hard to ensure minimal disruption to patients during the redesign work.

**What about Neonatal and other services?**

We are all aware that our neonatal services require additional investment to ensure that our most vulnerable babies are being cared for in the best environment possible. We have this year taken the difficult decision to reduce the number of cots in order to reduce the risk of infection. We want to invest urgently in our Neonatal estates and are actively working with NHS Improvement (our regulator) on a business case for significant investment in our neonatal service. We will ensure that you are kept up to date on progress as we know more over the next few weeks.

To further mitigate clinical risks and provide safety assurances, we are also planning an additional £1m investment to provide consultant cover and to address other issues highlighted in the clinical case for change.

**Our financial challenge**

Although we are investing in our services, there is also a significant financial challenge to address. Last year the Trust was required to live within a financial target which allowed for a £7.0m deficit. Thanks to everybody's hard work, we managed to stay within that target deficit. In this new financial year (2017/18) we have a shortfall of £4m.

This means that there will continue to be a significant focus on good financial management and as always we will need to rely on the continued commitment and support of staff to ensure we meet our financial responsibilities in a way which does not impact on patient care.

There have been a number of ideas already generated by staff that have contributed to new ways of working and have helped us use our resources more efficiently and effectively – such as the Hospital Taxi Car service. No idea is too big or too small if it helps the Trust address its challenges. So as well as the Trust wide projects, please also speak to your managers if you have ideas about how we could work more efficiently.

**Quality patient care is our number one priority**

Despite the challenges we have faced over recent years and will continue to face for the foreseeable future, the main driver for all our decision making is quality patient care. No decision we make will compromise the excellent quality of care we provide, which is why we are working extremely hard now to ensure our services are both fit and safe for the immediate and long-term future. Patient safety is always our number one priority.

**Got any questions? Please ask us**

We understand that there are lots of changes happening at Liverpool Women's at the moment and some of the information and progress being made can at times be confusing for staff, patients and our local community. Our staff members are best placed to explain our plans and next steps to our patients and others so hopefully this briefing will help you do that. We will continue to keep you updated on all major developments and plans.

If you would like me or another member of the Executive Team to come along to one of your department or team meetings to talk to you about any of the above, please contact 0151 702 4038 or email sacha.keating@lwh.nhs.uk

If you have any questions you would like to ask, you can also complete the form via the link below and we will provide answers through *In The Loop*, *Stafftrack,* as well as any other team meetings or engagement opportunities across department areas where appropriate. Ask your questions here:

**https://goo.gl/forms/FFfUhHjvQnNobYUm2**

Kathryn Thomson

**18th April 2017**

**Dame Lorna EF Muirhead DCVO DBE**
Her Majesty's Lord-Lieutenant of Merseyside

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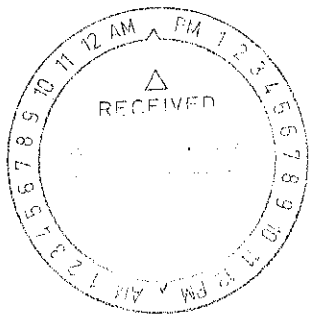


April 2017

Dear Michelle.

You may be aware that my term of office as Lord-Lieutenant comes to an end in September 2017 after eleven wonderful years representing Her Majesty in the County of Merseyside.

During that time I have been very privileged to be your Patron and have witnessed the excellent work your organisation does.

I am very conscious that my direct involvement has been scarce since I am Patron of many organisations throughout Merseyside, but I hope that at least to have had my endorsement for the work you do has been helpful to you.

It has been a very great privilege to be involved with you in your important work and I wish you all the very best for the future.

Yours Sincerely

Lorna.

Dame Lorna EF Muirhead DCVO DBE
Her Majesty's Lord-Lieutenant of Merseyside

17/120

**Board of Directors**

**Committee Chair's report of Finance Performance and Business Development Committee meeting held 24 April 2017**

## 1. Meeting Quorate: Yes

## 2. Agenda items covered

- The Committee received assurance that the Trust had delivered its 2016/17 control total, improving on the original plan by £1.3m. This position includes £2.8m planned Sustainability and Transformation Funding (STF), an additional £0.7m of STF Incentive funding and £0.6m non-recurrent improvement in year.
- Cost Improvement Programme (CIP) Update: The Committee received an update on the Trust's CIP Performance for 2016/17 and noted that of the 2016/17 £2m CIP target, the Trust delivered £1m on a recurrent basis. Plans were in place to deliver the CIP shortfall in 2017/18. The Committee noted the challenging financial environment to deliver the 2017/18 CIP plans of £3.7m.
- Performance dashboard, Month 12: The Committee noted that one of the 15 Monitor Key Performance Indicators (KPI's) had been red rated relating to agency staffing which was above the agreed agency staffing cap for the first time. The Committee noted that half of the agency work was accounted for by medical staffing. The majority of the KPI's that have triggered red or amber rating were those reported throughout 2016/17 and related to local indicators set by the Trust. The Committee noted that some of the targets for Gynaecology may not be achieved whilst the estate redesign being undertaken. During the time estate changes were taking place the team was focussing on ensuring patient safety.
- Electronic Patient Record (EPR) Programme: the Committee were informed that delivery of the EPR programme had commenced with a go live date of June 2018. The committee discussed staff awareness of the EPR programme and were informed that staff were aware of the project but not of the complexities involved and awareness sessions with senior staff would be increased to obtain their buy in and support. The Committee recommended that the Board of Directors should receive a progress update report at its 2nd June 2017 meeting.
  - Global Digital Exemplar (GDE) programme: The Committee received notification that The Royal Liverpool & Broadgreen University Hospitals NHS Trust (RLBUH) was one of 16 successful trusts to be accepted on the GDE programme. The Committee was informed that the objective of a GDE trust was to step up digitisation efforts and achieve HIMSS Level 7, a US benchmark of electronic medical records maturity, something not yet achieved by an English NHS hospital trust. As part of the GDE programme, each GDE Trust would nominate two Fast Follower Trusts and develop standard blueprints that other Trusts would subsequently follow. A Fast Follower Trust would aim to achieve HIMSS level 5 by the end of the programme in May 2020 which attracts £5m funding. The Committee having received notification that the RLBUH have requested to nominate this Trust, LWH, as its fast follower, along with a Trust in the North East approved the application of the fast follower expression of interest.
- Soft FM Tender: the Committee noted that the Soft FM tender exercise had been concluded and the contract awarded to OCS as the preferred partner.
- Hewitt Centre update: The Committee received a comprehensive update report from Hewitt Fertility and received assurance on the work being undertaken to stabilise the service in terms of income, activity and expenditure. The Committee noted that the more formalised

Business Plan approved by the Board had been committed to be the management team within Hewitt.

- ~ Board Assurance Framework: The Committee reviewed the new BAF template and the two risks that had been aligned to the Committee. The Committee agreed the risks and risk scores: The Trust is not financially sustainable beyond the current financial year [2017/18], the risk score to remain at 25; and Failure to deliver the annual financial plan, the risk score to remain at 20 with a target risk score of 10 by the end of the financial year.
- ~ Risk Appetite Statement 2017/18: The Committee review the Risk Appetite Statement 2017/18 and agreed to recommend the appetite and risk tolerance level of "moderate" against the key strategic aim, 'to be ambitious and efficient and make best use of available resources'.
- ~ FPBD Committee Annual report 2016/17: The Committee noted the FPBD Annual Report 2016/17 which would be appended to the Chair Report for reporting purposes to the Board.

## 3. Board Assurance Framework (BAF) risks & Risk Appetite Statement 2017/18

- ~ The Committee noted the BAF and Risk Appetite Statement 2017/18

## 4. Issues to highlight to Board

- ~ To note the Soft FM contract award to OCS as the preferred partner.
- ~ To note the the BAF risks; risk scores; and Risk Appetite tolerance level.

## 5. BAF recommendations

- ~ To note the BAF risks and risk scores

## 6. Action required by Board

- ~ To Note the FPBD Committee Annual report 2016/17

# Liverpool Women's NHS Foundation Trust

## Finance, Performance & Business Development Committee Annual Report 2016/17

## The Finance, Performance & Business Development Committee

The Committee is responsible for reviewing the Trust's financial strategy, performance and business development.

It completes these responsibilities as follows;

### Finance and performance

a. Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board.
b. Review progress against key financial and performance targets
c. Act on behalf of the Board to approve NHS Improvement returns.
d. Review the service line reports for the Trust and advise on service improvements
e. Provide oversight of the cost improvement programme
f. Oversee external financing & distressed financing requirements
g. Oversee the development and implementation of the information management and technology strategy
h. Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework

### Business planning and development

i. Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management
j. Advise the Board and maintain an oversight on all major investments, disposals and business developments.
k. Advise the Board on all proposals for major capital expenditure over £500,000
l. Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy

This remit is achieved through the Committee being appropriately constituted, and by the Committee being effective in ensuring internal accountability and the delivery of assurance services.

This report outlines how the Committee has complied with the duties delegated by the Trust Board through the terms of reference.

## Constitution

The Finance, Performance and Business Development Committee is accountable to the Board of Directors.

Membership during the year comprised;

- Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- Chief Executive

- Director of Finance
- Director of Operations

Meetings were also attended by other senior management staff as appropriate.

The Committee met in accordance with the frequency laid out in its terms of reference which is at least five times per year. The Terms of Reference were reviewed in April 2016, November 2016 and March 2017.

Nine meetings were held during the financial year 2016/17 to reflect the financial challenges faced by the Trust. Members participated by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference.

## Key Achievements

Significant financial and strategic matters were adequately discussed with appropriate regard to risk, generating appropriate actions which were followed up on a timely basis. Key achievements are noted below:

### *Performance reporting*

The Committee reviewed the detail of the financial and operational plans for 2016/17 in April 2016 and recommend approval of the plans to the Board. During the 2016/17 financial year the Committee received oversight of the performance management of the delivery of the plans.

### *NHS Improvement (NHSI) Reporting and Distressed Finance Funding*

The Committee received quarter 1 and quarter 2 NHSI quarterly returns. The Committee has noted changes to the reporting requirements since Monitor became part of NHS Improvement.

The Committee noted the requirements for Distressed Financing from the Department of Health, supporting a change in the type of finance received in order to benefit from improved interest rates.

The Committee supported the receipt of STF Incentive funding through delivery of an improved control total.

### *Monitoring the Trust CIP programme*

The Committee received and reviewed on a regular basis the Trust's progress against its challenging CIP targets for 2016/17.

The Committee reviewed and challenged the financial targets of each scheme as well as receiving assurance that the Quality Impact Assessments behind each one had been approved by the Medical Director and Director of Nursing and Midwifery.

The Committee has also reviewed the CIP post implementation review and governance processes in place around the delivery of CIP.

***Strategic Options***

The Committee supported the Strategic Options business case and monitored the consultation process led by the Liverpool Clinical Commissioning Group.

***Turnaround and Transformation***

The Committee received updates from the Turnaround and Transformation Committee in relation to the identification of CIP schemes for 2017/18 and 2018/19 and regularly received the Chairs reports from the Turnaround and Transformation Committee.

***MARS Scheme***

The Committee approved the introduction of the MARS scheme during 2016/17, which was open for applications in January 2017.

***IM&T strategy***

The Committee have monitored the progress of the implementation of the IM&T Strategy receiving detailed quarterly updates from the Chief Information Officer. Notably the Committee has considered detailed reports relating to the implementation of the Electronic Patient Record business case.

***Hewitt Fertility Centre (HFC)***

The Committee received updates regarding the future delivery model for the Hewitt Fertility Centre services, challenging performance against the financial plan. The Committee noted the Board of Directors decision to drive discussions and monitor performance more robustly through a Fertility Board Oversight Group for a six month term covering October 2016 – March 2017.

The Committee noted the release from the joint venture with the Kings Trust.

***Business Assurance Framework (BAF)***

The Committee have reviewed the Board Assurance Framework in line with the business cycle of activities and the updated risk management policy. The Committee have held discussions over the rating of specific risks and amended the BAF accordingly.

## Conclusion

In evaluating its achievements it is concluded that the Finance, Performance & Business Development has achieved its objectives for the Financial Year 2016/17.

**Finance, Performance & Business Development Committee Chair**
**April 2017**

## Finance, Performance & Business Development Committee Attendance 2016/17

| Members | 25 April 2016 | 20 June 2016 | 25 July 2016 | 26 Sept 2016 | 24 Oct 2016 | 21 Nov 2016 | 30 Jan 2017 | 20 Feb 2017 | 20 Mar 2017 |
|---|---|---|---|---|---|---|---|---|---|
| Jo Moore (Chair – Non Executive) | ✓ | ✓ | ✓ | ✓ | AP | ✓ | ✓ | ✓ | ✓ |
| Ian Haythornthwaite (Non-Executive) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Phil Huggon (Non-Executive) | AP | ✓ | AP | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Vanessa Harris (Director of Finance) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | AP |
| Kathryn Thomson (Chief Executive Officer) | ✓ | AP | X | AP | AP | AP | ✓ | AP | ✓ |
| Jeff Johnston (Director of Operations) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | AP | ✓ |
| **In regular attendance** | | | | | | | | | |
| Jenny Hannon | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| David Walliker | | | ✓ | | ✓ | | ✓ | | |
| Jonathan Lofthouse | | | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Colin Reid | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

**Other Attendees:**

| | |
|---|---|
| David Astley | Non-Executive Director |
| Cath Barton | General Manager |
| Dianne Brown | Director of Nursing & Midwifery |
| Robert Clarke | Chairman |
| Helen Fogg | Managing Director, Hewitt Centre (Oct 2016 until Jan 2017) |
| Simon Harrison | Interim Managing Director, Hewitt Centre (until Sept 2016) |
| Jennifer Huyton | Head of Strategic Finance |
| Ian Knight | Non-Executive Director |
| Andy Large | Head of Finance |
| Andrew Loughney | Medical Director |
| Neil Rogers | Interim Senior Manager, Hewitt Centre (from February 2017 until present) |
| Claire Scott | Divisional Accountant |
| Michelle Turner | Director of Workforce & Marketing |
| Katherine Wright | Head of Communications, Marketing and Engagement |

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Putting People First Committee meeting held 28 April 2017

1. Was the quorate met? Yes

2. Agenda items covered

- Review of HR BAF Risks & Risk Appetite Statement 17/18
- PDR Training Compliance & CQC Well Led Standard
- Staff Experience Story – Maternity
- Maternity Workforce Review
- HR Directors Report
- Workforce KPI Report
- Annual Settlement Agreement Report
- Counter Fraud Audit Report – Secondary Employment & Sickness Absence
- Annual Raising Staff Concerns Report – Freedom to Speak Up Guardian
- Update on 7 Day Services
- Annual Workforce Profile Report – Equality & Diversity
- Communications, Marketing & Engagement Strategy - Annual Review 16/17 & Annual Workplan 17/18
- Guardian of Safe Working for Junior Doctors – Quarterly Report
- Volunteer Strategy – 6 month review
- Staff Survey 2016 Results & Action Plan
- Director of Medical Education Annual Report
- Health & Wellbeing Strategy – 6 month review including CQINS performance
- Policies approved
    - Establishment Control SOP
    - Retirement Policy & Procedure
    - Policy for Prevention & Management of Work Related Stress
    - Job Matching & Evaluation Policy & Procedure
    - E-Rostering Policy
    - Annual Leave Policy
    - Medical Appraisal & Revalidation Policy
    - Remediation Policy
    - Exception Reporting Policy

- Committee Annual Report 2016/17, 2017/18 Business Cycle & Review of Terms of Reference
- Sub Committee Chair Reports
    - Education Governance
    - Nursing & Midwifery Board
    - Joint Local Negotiating Committee
    - Diversity & Inclusion Committee

3. Risk Register risks reviewed - Yes

4. Issues to highlight to Board of Directors

- Turnover target revised based on benchmarked data both nationally and locally to 13%

NHS

- Maternity Service Workforce Review identified new risk associated with recruitment of experienced Band 6 midwives

- Noted the appointment of the Guardian of Safe Working and received a report which highlighted continuing reliance on LW junior doctors undertaking locum shifts in context of national shortage of junior doctors and the known difficulties in recruiting to gaps in rotas and Committee sought assurance that there was appropriate focus to addressing issue within the respective services

- Marketing of LWH & Communications Strategy – identified the need to refresh the messaging both internally and externally associated with LWH future both in the immediate and longer term; and the need for a focused marketing campaign to promote working @ Liverpool Women's

- Freedom to Speak Up Guardian Annual Report demonstrated role is well embedded and staff confidence increasing in raising concerns internally

- Annual Settlement Agreement Report – The Committee were assured of the appropriate application of Settlement Agreements, noting that all were within contractual arrangements, the majority being associated with the MARS scheme.

- Health & Wellbeing Strategy Action Plan 16/17 – The Committee were assured by the significant progress made against the Action Plan required to achieve the relevant CQIN target.

- Director of Medical Education Annual Report – The Committee were assured that the Trust was continuing to provide a high quality medical education experience to doctors in training and that appropriate action had been taken to address those areas for improvement identified following the visit of Health Education England (Deanery)

## 5. Risk Register recommendations

BAF Workforce Risk current score to be increased from 10 (2x5) to 15 (3x5) with a target risk score of 10 (2x5) by 31.3.18

Risk Appetite 17/18 set at Moderate for Workforce

## 6. Action required by Board of Directors

1) To approve the rescoring of the BAF Workforce Risk from 10 to 15 as outlined above.

2) To approve the agreed risk tolerance level for 2017-18 for the key strategic aim 'To Develop a Well led, capable and motivated workforce' as Moderate.

3) To note the Committee's Annual Report 2016/17

4) To approve changes to the Terms of Reference of the Committee

AUTHOR NAME Tony Okotie

DATE 28 April 2017

# Liverpool Women's NHS Foundation Trust

## Putting People First Committee Annual Report 2016/17

## Putting People First Committee

The aim of the Putting People First Committee is to develop and oversee the implementation of the Trust's People Strategy (integrated workforce and organisational development strategy – One Team, One Goal: Putting People First) providing assurance to the Board of Directors that this is achieving the outcomes sought and required by the organisation. The terms of Reference of the Committee were reviewed in April 2016 and are as follows

In discharging these duties the Committee is responsible for:

a. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process
b. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee)
c. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce
d. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors
e. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues
f. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys
g. Reviewing and approving partnership agreements with staff side
h. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues, including but not limited to equality and diversity
i. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings
j. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required.
k. Receiving and considering issues from other Committees when appropriate and taking any necessary action.

This remit is achieved firstly, through the Committee being appropriately constituted, and secondly, by the Committee being effective in ensuring internal accountability for implementation of the strategy through appropriate assurance mechanisms.

This report outlines how the Committee has complied with the duties delegated by the Trust Board through its terms of reference.

## Constitution

The Committee membership (as appointed by the Board of Directors) comprises:

- Non-Executive Director (Chair)
- 2 other Non-Executive Directors
- Director of Workforce & Marketing
- Director of Nursing & Midwifery
- Associate Director of Operations / General Manager
- Staff Side Chair
- Medical Staff Committee representative
- Representative from the Nursing & Midwifery Board
- Senior Finance Manager

In addition the Committee was supported by senior HR and OD staff, Chair of Education Governance Committee, with other officers attending as required.

Members can participate in meetings in person or by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum

This is a sub-committee of the Board of Directors established to ensure effective implementation of the integrated workforce and organisational development strategy.

Five meetings were held during the financial year 2016/17. An attendance sheet is attached for information at the end of this report. The Committee was quorate for all meetings, with the exception of the final meeting In January 2017. However, no decisions were made and no policies ratified.

The Chair provides a report into the Board of Directors after every meeting.

## Achievements

The Committee's primary focus throughout the year was on the effective implementation of the year 2 goals of the People Strategy. The Committee also focused on the key Board Assurance Framework risks remitted to the Committee for oversight, review and update. These included:

- The risk to patient experience and outcomes associated with low levels of Staff Engagement and lack of Leadership capability/capacity
- The risks associated with not having capacity to deliver services to an appropriate standard through a workforce of the right number, with current knowledge, competency and experience
- The risks associated with Industrial Action

In 2016/17, the Committee also;

- Agreed its Risk Appetite Statement for relevant risks
- Undertook a deep dive and gained assurance with respect to workforce risks in Maternity, Genetics, Hewitt Fertility, Gynaecology, Corporate, Neonates and Theatres. Staff Stories were also received for each of these areas.
- Monitored all workforce related Key Performance Indicators
- Gained assurance that robust processes were in place to maintain safe service delivery during periods of junior doctor industrial action and updates on the implementation of the new 2016 contract

- Gained assurance around the processes to deliver and monitor compliance with mandatory training requirements, in particular Information Governance training
- Considered the Annual Staff Survey results and were pleased to note the continued improvement in overall staff engagement
- Gained assurance that there were no trends of concern with respect to the Trust's Disciplinary and Grievance processes
- Developed the role of the F2SUG and further developed the Whistleblowing policy
- Gained assurance that appropriate progress was being made in line with the Health & Wellbeing Strategy
- Regularly reviewed the progress made against the Equality Delivery System Goals & WRES and selected the areas for focus for improvement for 2016/17 and identified the areas for improvement within the Trust and remitted the actions to the Diversity & Inclusion Committee
- Received the Workforce Profile Report and identified areas for further action with specific regard to the employment of those with a disability
- Received updates on the Fit for Future Generations programme and oversaw workforce related cost improvement schemes
- Ratified policies to ensure the HR policy schedule was in date
- Approved the project plan for the implementation of ESR Self-Service
- Received regular HR Director reports
- Received a review of the HR Transactional Services, which provided assurances to the Committee on the service provided.
- Were assured by six monthly and annual reviews of the Putting People First Strategy which demonstrated progress being made in accordance with the objectives of the Strategy
- Reviewed the findings of the Payroll and Pre-employment Internal audit and agreed the actions required to provide greater assurance
- Were updated on the requirements of the GMC Educational Standards and the HENW Education Standards Audit and were assured by the actions and progress made to ensure compliance
- Were advised of the proposed introduction of the Apprenticeship Levy and the implications for the Trust
- Reviewed the Settlement Agreements entered into by the Trust
- Reviewed the Volunteer Strategy and progress against its aims
- Reviewed the Communications & Engagement Strategy and progress against its aims
- Reviewed progress against the Nursing & Midwifery Strategy and safe staffing reports
- Approved the introduction of a Talent Management programme
- Approved the revised Leadership Framework

The Committee reviewed and approved the following policies;

- Annual Leave Policy for Medical Staff
- Capability Policy and Procedure
- Clinical Excellence Awards Policy
- Dignity at Work Policy
- Flexible Working Policy
- Induction Policy
- Maintaining High Professional Standards
- Mandatory Training Policy
- Maternity, Paternity & Adoption Policy
- Organisational Change, Pay Protection and Redundancy Policy
- Overpayments, Underpayment & Incorrect Payments Policy
- Performance & Pay Progression Policy
- Personal Use of Social & Attributed Media Policy
- Policy for the Supervision and Assessing Competence of Medical Staff in Training
- Recruitment Policy
- Redeployment Policy

- Removal & Related Expenses for Consultant Medical Staff SOP
- Secondments & Acting Up Policy
- Snr Medical Staff Covering Jnr Medical Staff (out of Hours) Policy
- Special Leave Policy
- Supporting Staff Following a Work Related Traumatic or Serious Incident Policy
- The Management of Hepatitis B, Hepatitis C and HIV Infected Healthcare Workers Policy
- Whistleblowing Policy and Procedure

The Committee received minutes from the following reporting Committees:

- Partnership Forum
- Joint Local Negotiating Committee
- Education Governance Committee
- Diversity & Inclusion Committee
- Nursing & Midwifery Board

## Moving Forward in 2017/178

In 2017/18 the Committee will continue to strengthen its assurance approach by undertaking service 'deep dives' requiring leaders of the Trust's clinical and corporate services to present their key workforce risks and provide assurance to the Committee that these risks are appropriately identified, mitigated for and actively managed.

The Committee will continue to analyse trend data arising from the monthly KPI data and workforce planning reviews and again identify and mitigate any risks.

The Committee will meet five times per year and additional meetings will be arranged if necessary. The main functions of the Committee remain the same as the previous year in:

1) Ensuring appropriate levels of assurance are provided to the Board of Directors in relation to key risks relating to the workforce as identified in the Board Assurance Framework

2) Overseeing implementation of the Putting People First Strategy.

The Committee will continue to focus on ensuring relevant assurance on key risks identified within the Board Assurance framework.

**Putting People First Committee Chair**
**April 2017**

**Putting People First Committee Attendance 2016/17**

| Committee Member | 15 April 2016 | 17 June 2016 | 23 Sept 2016 | 24 Nov 2016 | 27 Jan 2017 |
|---|---|---|---|---|---|
| Tony Okotie (Chair – Non Executive) | ✓ | ✓ | ✓ | ✓ | ✓ |
| David Astley (Non Executive) | | ✓ | ✓ | | ✓ |
| Ian Knight (Non Executive) | | ✓ | ✓ | ✓ | ✓ |
| Michelle Turner (Director of Workforce and Marketing) | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dianne Brown (Director of Nursing & Midwifery) | ✓ | **AP** | **AP** | ✓ | ✓ |
| Jeff Johnston (Director of Operations) | **AP** | **AP** | ✓ | **AP** | ✓ |
| Ruben Trochez (Education Governance Committee Chair) | **AP** | **AP** | ✓ | ✓ | ✓ |
| Liz Adams (Medical Staff Committee Representative) | **AP** | **AP** | **Non Member** | | |
| Mark Clement-Jones (Medical Staff Committee Representative) | **NM** | **NM** | ✓ | ✓ | **AP** |
| Cheryl Farmer (Equality & Human rights manager) | ✓ | ✓ | ✓ | **AP** | **AP** |
| **In regular attendance** | | | | | |
| Susan Westbury | ✓ | **AP** | | ✓ | ✓ |
| Cath Barton | ✓ | ✓ | ✓ | **AP** | ✓ |
| Gill Curry | ✓ | ✓ | | ✓ | ✓ |
| Jean Annan | ✓ | ✓ | ✓ | ✓ | ✓ |
| Janet Hinde | ✓ | ✓ | ✓ | ✓ | ✓ |
| Chris McGhee | | **AP** | ✓ | ✓ | ✓ |

**✓ = In Attendance AP = Apologies Given x = Non Attendance NM = Non Member**

Other Invited Attendees during 2016/17:

| | |
|---|---|
| Alison Ewing | Pharmacy Manager |
| Elaine Willis | Pharmacy Manager |
| Carla Marshall | HR Business Partner |
| Claire Scott | Divisional Accountant |
| Gill Diskin | Matron Maternity |
| Nicky Maggs | Theatres Manager |
| Tracy McNulty | Theatres |
| Edwin Djabatey | Clinical Director Anaesthetics |
| Katherine Wright | Head of Communications |
| Alison Edis | Deputy Director of Nursing and Midwifery |
| Susan Milner | Non-executive director |
| Simon Davies | HR Advisor |
| Joanne Topping | Consultant Obstetrician (representing MSC) |
| Val Irving | Neonates Matron |
| Gina Barr | Voluntary Services Manager |
| Kathy Smith | Medical Education Manager |

| | |
|---|---|
| Rachel London | OD Business Partner |
| Gill Walker | Matron |
| Denise Carter | Gynaecology Outpatient/Endometriosis Nurse |
| Helen Fogg | Managing Director Hewitt |
| Nicola Murdoch | Head of Operations |
| Roger Mountford | Consultant  Molecular Geneticist |
| Alison Carroll | Organisation + People Development Facilitator |
| Phil Huggon | Non-executive director |

# PUTTING PEOPLE FIRST COMMITTEE
# TERMS OF REFERENCE

| | |
|---|---|
| **Constitution:** | The Committee is established by the Board of Directors and will be known as the Putting People First Committee (the Committee). |
| **Duties:** | The Committee is responsible for:<br><br>a. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process<br>b. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee)<br>c. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce<br>d. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors<br>e. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues<br>f. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys<br>g. Reviewing and approving partnership agreements with staff side<br>h. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues, including but not limited to equality and diversity<br>i. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings<br>j. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required.<br>k. Receiving and considering issues from other Committees when appropriate and taking any necessary action. |

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| **Membership:** | The Committee membership will be appointed by the Board of Directors and will consist of<br><br>• Non-Executive Director (Chair)<br>• 2 other Non-Executive Director<br>• Director of Workforce & Marketing<br>• Director of Nursing & Midwifery<br>• Director of Operations / General Manager<br>• Staff Side Chair<br>• Medical Staff Committee representative<br>• Representative from the Nursing & Midwifery Board<br>• Senior Finance Manager<br><br>Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum<br><br>The Board of Directors will appoint a Non-Executive Director as Chair of the Committee Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.<br>~~and another Non-Executive member to be Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent.~~ |
| **Quorum:** | A quorum shall be four members including:<br>• The Chair or one other Non-Executive Director<br>• One Executive Director<br>• Director of Operations/General Manager<br>• Staff side Chair or Medical Staff Committee representative |
| **Voting:** | Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority. |
| **Attendance:** | **a. Members**<br>Members will be required to attend a minimum of 75% of all meetings.<br><br>**b. Officers**<br>HR & OD senior team, Health & Wellbeing Manager, Education Governance Chair shall normally attend meetings.<br><br>Members may send a nominated representative to attend meetings on their behalf when they are not available, provided they are sufficiently senior and have the authority to make decisions.<br><br>Other executive directors, officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. |

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| | Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights. |
| **Frequency:** | Meetings shall be held at least 4 times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust. |
| **Authority:** | The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.<br><br>The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. |
| **Accountability and reporting arrangements:** | The Putting People First Committee will be accountable to the Board of Directors.<br><br>The minutes of the Putting People First Committee meetings will be formally recorded and submitted to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it, or require executive action.<br><br>Approved minutes will also be circulated to members of the Audit Committee.<br><br>The Committee will report to the Board annually on its work and performance in the preceding year.<br><br>Trust standing orders and standing financial instructions apply to the operation of the Putting People First Committee. |
| **Monitoring effectiveness:** | The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. |
| **Review:** | These terms of reference will be reviewed at least annually by the Committee. |
| | |
| **Reviewed by Putting People First Committee:** | 28 April 2017 |
| **Approved by Board of Directors:** | 1 July 2016 |
| **Review date:** | April 2018 |
| **Document owner:** | Colin Reid, Trust Secretary<br>Email: colin.reid@lwh.nhs.co.uk Tel: 0151 702 4033 |

| | |
|---|---|
| **Agenda item no:** | 2017/122 |

| | |
|---|---|
| **Meeting:** | Trust Board Meeting |

| | |
|---|---|
| **Date:** | 5 May 2017 |

| | |
|---|---|
| **Title:** | Mortality Strategies |

| | |
|---|---|
| **Report to be considered in public or private?** | Public |

| | |
|---|---|
| **Where else has this report been considered and when?** | |

| | |
|---|---|
| **Reference/s:** | GACA – 24 March 2017<br>Board - 7 April 2017 |

| | |
|---|---|
| **Resource impact:** | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **What is this report for?** | **Information** | | **Decision** | **X** | **Escalation** | | **Assurance** | **x** |

| | |
|---|---|
| **Which Board Assurance Framework risk/s does this report relate to?** | |

| | |
|---|---|
| **Which CQC fundamental standard/s does this report relate to?** | Reg 17 & 12 |

| | |
|---|---|
| **What action is required at this meeting?** | Board is asked to approve:<br>1. the Adult Mortality Strategy; and<br>2. Perinatal Mortality Strategy |

| | |
|---|---|
| **Presented by:** | Andrew Loughney, Medical Director |
| **Prepared by:** | |

This report covers (tick all that apply):

| **Strategic objectives:** | |
|---|---|
| To develop a well led, capable motivated and entrepreneurial workforce | **X** |
| To be ambitious and efficient and make best use of available resources | **X** |
| To deliver safe services | **X** |
| To participate in high quality research in order to deliver the most effective outcomes | |

| | |
|---|---|
| To deliver the best possible experience for patients and staff | **X** |

| **Other:** | | | |
|---|---|---|---|
| Monitor compliance | | Equality and diversity | |
| Operational plan | | NHS constitution | |

| **Publication of this report** (tick one)**:** | |
|---|---|
| This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting | **x** |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedom of Information Act 2000, because such disclosure might constitute a breach of confidence | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust | |

Included in this document are:

1. Adult Mortality Strategy
2. Perinatal Mortality Strategy

The Board has been issued with the above for approval. A presentation will be provided on the day of the Board that will highlight the requirements of the Strategies and Board responsibilities

Board is asked to approve:

1. the Adult Mortality Strategy; and
2. the Perinatal Mortality Strategy

# Adult Mortality Strategy

## Liverpool Women's NHS Foundation Trust

**Version 1.0**
**March 2017**

## Contents

# 1 Introduction

Around 500 000 people die in the UK every year and of these, nearly half die in an NHS hospital.[1] While many of these deaths represent the expected end point of a known disease process, the CQC have recently highlighted the need for NHS Trusts to review the care they provide [2] so that they can learn from their experiences (hence improve the way that they provide care), fulfil their duty of candour and make themselves accountable for any deficiencies or failures that they might have.

The CQC and NHS England[3] recommend that individual NHS trusts should work with their commissioners to review and improve their local approach following the death of people receiving care from their services. Emphasis is given to the need for their Boards to ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated when appropriate and that learning from deaths is shared and acted upon. Engagement with families and carers is also prioritorised in these new national recommendations.

Liverpool Women's NHS Foundation Trust recognises that although most of the adult death it encounters is the expected end point of a known disease process, the principles described above are equally valid to its own services. In the Trust's Risk Management Strategy, commitment is given to minimise risk through the systematic embedding of relevant, efficient and effective risk management processes. Since the Trust's core purpose is to provide clinical care, its foremost risks are those that are clinically based and the ultimate clinical risk is that of death. In acknowledgement of that fact, the Board of Directors has approved this Adult Mortality Strategy, which relates to adult disease across the specialties of obstetrics and gynaecology.

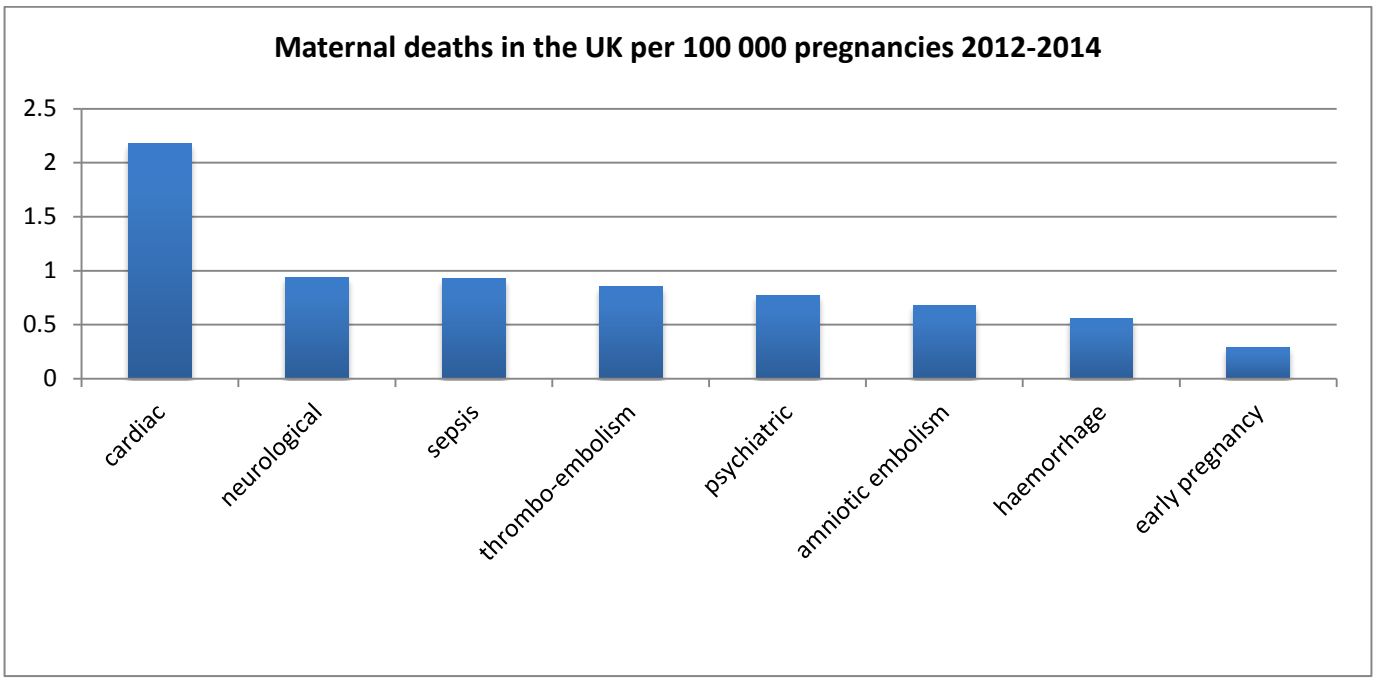
This strategy is relevant and applies to all of the Trust's clinical and managerial staff because the management of adult mortality is a shared responsibility.

# 2 Causes of Mortality

The causes of adult mortality (and as a surrogate, severe morbidity) are similar between gynaecology and obstetrics. In gynaecological practice, for example, the most common reasons for transferring a patient to an intensive care unit after surgery are:[4, 5]

- recovery from haemorrhage
- treatment of sepsis
- management of pre-existing cardiovascular disease
- recovery from a procedure-related injury
- treatment of thrombo-embolism

For comparison, the profile of maternal death in the UK during or shortly after pregnancy is shown in the chart below.[6]




Common themes emerge that point to the importance of multidisciplinary team working and optimising the management of some specific clinical conditions that are encountered in gynaecological and obstetric practice, including cardiac disease, sepsis, venous thrombo-embolism and haemorrhage. Consequently, the key elements of this strategy apply equally to gynaecology and obstetrics.

## 3 Aim of the Strategy

The aim of this strategy is to set out the Trust's vision for managing mortality. There are four key elements to be met:

**Prevention** Our aim is to prevent all avoidable adult mortality in the Trust across the specialties of gynaecology and obstetrics.

**Analysis** Our aim is to gather detailed intelligence on all individual instances of adult mortality in the Trust, to identify local issues and themes arising from those events, to audit key areas of clinical practice that relate to mortality and to consider all relevant national documents.

**Response** Our aim is to respond to our analyses by production of SMART Action Plans, including a commitment to seeing those plans through to completion and a commitment to disseminating the intelligence gathered to all relevant clinical and managerial groups. After completion of these action plans we will ensure that full benefit has been achieved by measuring relevant and related clinical outcomes.

**Bereavement** Our aim is to provide bereaved families with an environment tailored to their needs, to raise awareness of the needs of bereaved people amongst our clinical staff and to comply in full with the Duty of Candour in response to the death of a patient. Bereaved families will form a central part in our investigatory processes when there has been an adult death.

## 3.1 Prevention

To minimise the risk of adult mortality, the following must be provided:

- adequate numbers of clinical staff with the correct mix of clinical skills
- ready availability of all necessary equipment and facilities
- accessible guidelines for the treatment of clinical conditions associated with adult mortality

**Relocation** The key long term strategy for the prevention of death is therefore to relocate all of the Trust's acute services to a hospital site that is already providing multidisciplinary acute adult care. This would give immediate access to medical and surgical teams from other specialties, to assist with a full range of acute and sub-acute obstetric, gynaecological and anaesthetic complications. A specialised cardiac arrest team would also then be available and there would be ready access to an on-site blood bank, full imaging and laboratory diagnostic services and a Level 3 Intensive Care Unit. The Board of Directors is committed to pursuing this strategy through

a process of negotiation with local Clinical Commissioning Groups, NHS Improvement and NHS England and through a process of discussion with the public.

**Business Plan** Since relocation is not an immediately achievable option, the Board of Directors has also put forward a two year Business Plan (2017-2019) that will address each of the Trust's key present clinical weaknesses in turn. This appears as Appendix A at the rear of this document.

**Present Resources** It is recognised that the full implementation of this Operational Plan will require the support of external regulatory and funding bodies, which is outwith the direct control of the Trust. Therefore, in addition to the measures included in the Operational Plan, the Trust is committed to optimising its strategy for the prevention of death using present resources. Six examples of the most directly relevant preventative measures that have already been implemented using present resources are as follows:

- A Major Haemorrhage Protocol has been developed to optimise the use of available resources and expertise on the Crown Street site. It incorporates bespoke elements, including the use of on-site blood clotting analysis to guide administration of blood products. Training in major haemorrhage management forms part of the Mandatory Training Programme for all clinical staff in the Trust.

- The Sepsis Bundle has been developed in line with national guidance, to ensure that rapid detection of sepsis and the correct medical and nursing response is provided. Training in sepsis management forms part of the Mandatory Training Programme for all clinical staff in the Trust.

- Adult Resuscitation (Basic Life Support) forms part of the Mandatory Training Programme for all clinical staff in the Trust. Since the medical element of the resuscitation team is drawn from available anaesthetists, obstetricians and gynaecologists on-site, all medical staff in the Trust are trained in the use of defibrillators.

- Level 2 HDU Care is provided for gynaecological and obstetric patients on-site, with support being provided to the Trust's nursing and midwifery staff from Consultant Anaesthetists and a Practice Educator based at The Royal Liverpool Hospital.

- Pregnant women with cardiological conditions are cared for throughout their pregnancies by a Consultant Cardiologist and a Consultant Obstetrician in tandem, who run a specialised antenatal clinic for that purpose.

- Case by case selection has allowed an increasing number of our most complex gynaecological cases to be operated upon at The Royal Liverpool Hospital, with access to colorectal and urological surgeons and elective access to an adult Intensive Care Unit.

**Clinical Guidelines** The maintenance of up to date clinical guidelines that cover our full scope of clinical activity adds to the culture of prevention of adult death in the Trust. In 2016, this was activity identified as one of the key responsibilities of the Effectiveness Leads, who are appointed to each of the Trust's clinical specialties. In February 2017, around 85% of all clinical guidelines in the Trust were ratified and up to date. Our strategy for the prevention of adult death includes the following commitment for the specialties of obstetrics and gynaecology:

- At any one time, at least 95% of all clinical guidelines will be ratified, maintained within their stated review date and available to view on the trust intranet. The 5% of remaining clinical guidelines that fall outside of this target will have an identified reviewer and an identified completion date for ratification.

This commitment will be achieved by August 2017. It will be monitored at Divisional Clinical Meetings, the Effectiveness Senate and ultimately by GACA.

## 3.2 Analysis

The Trust's strategy for analysis relies upon the following activities:

- gather detailed intelligence on all individual instances of adult mortality in the Trust
- identify local issues arising from each of those events individually
- explore themes that may be emerging from groups of events
- audit key areas of clinical practice that relate to mortality
- consider newly published relevant documents from external bodies

**Intelligence-Gathering Process** Appendices 2, 3 and 4 are flow charts that illustrate the intelligence-gathering processes that will be followed after expected gynaecological deaths, unexpected gynaecological deaths and all adult deaths in obstetrics. Expected gynaecological deaths are those that arise as the predicted end point of a known disease process. In this Trust, most expected deaths result from gynaecological cancers.

**Adult Mortality Audit Sheet** From April 2017, whenever there is an adult death in the trust, whether expected or not, an Adult Mortality Audit Sheet will be completed. This will record performance against a predefined set of standards, using the recognised and validated methodology detailed in PRISM studies.[7] In each clinical area, the Clinical Director will provide feedback to clinicians if individual errors or omissions in care have been identified by use of this audit tool. The forms gathered will be passed to the Head of Governance, who will pool the data and identify any emerging Trust-wide themes. These will be highlighted in the Quarterly Mortality Report, from July 2017 onwards.

**Root Cause Analysis** For unexpected gynaecological deaths and all maternal deaths, either a Level 2 or a Level 3 Root Cause Analysis is performed. One of the main aims of the Root Cause Analysis is to identify case-specific errors and systematic flaws. All Root Cause Analyses are scrutinised by the Head of Governance, who pools data and identifies any emerging Trust-wide themes. These Root Cause Analyses will continue but their lessons and SMART Action Plans will be highlighted in the Quarterly Mortality Report, from July 2017 onwards.

Responding to an adult death by use of the Adult Mortality Audit Sheet or by performing a Root Cause Analysis are forms of reactive risk management. The Trust's strategy is, however, planned to be both reactive and proactive. Proactive elements will include audit in key areas of clinical practice (as is already common practice), use of a newly created Adult Mortality Dashboard and horizon scanning for national documents of relevance to adult mortality.

**Clinical Audit Forward Plan** With respect to clinical audit, an annual Clinical Audit Forward Plan is presently formulated by the Associate Medical Director for Clinical Governance, after consultation with the Trust's Effectiveness Leads and after discussion with the Trust's Head of Governance. The content of the Clinical Audit Forward Plan is flexible but from April 2017 the Trust commits to the principle that it must include work of relevance to the highest risk areas for adult mortality including:

- haemorrhage
- psychiatric disease
- sepsis
- neurological disease
- venous thromboembolism
- cardiac disease

In each of these areas of audit, the Associate Medical Director for Clinical Governance will allocate a Consultant Lead who will ensure that the audit is completed within the timeframe of annual audit cycle and presented at the corresponding Directorate Clinical Meetings. All audit work performed against the above areas of clinical practice will therefore have been completed, presented and have recommendations made against them by March 2018.

**Adult Mortality Dashboard** At present, there is no adult mortality specific dashboard available in the Trust, to provide easily accessible data about the clinical outcomes of most relevance to the field. As part of the Trust's Adult Mortality Strategy, The Associate Medical Director for Clinical Governance will work with the Head of Governance and the Clinical Directors of Obstetrics, Gynaecology and Anaesthetics to create such a dashboard. A draft will be presented to the Safety Senate in July 2017 so that its content can be agreed. A functioning dashboard will be in use by September 2017, forming an agenda item for discussion at each Directorate Clinical Meeting in Obstetrics, Gynaecology and Anaesthetics. The Adult Mortality Dashboard will also appear as an integral part of the Quarterly Mortality Review, from September 2017.

**Horizon Scanning** With respect to horizon scanning for national documents of relevance to adult mortality, the following sources of information are monitored by the Safety Leads in Gynaecology, Maternity and Anaesthetics:

- CQC
- NHSLA
- NICE
- NPEU
- RCOG
- NCEPOD

Documents that are potentially relevant to adult mortality are summarised by the Safety Leads and presented to their respective Directorate Clinical Meetings for minuted discussion. Areas of concern and areas for improvement are then brought to the attention of the Associate Medical Director for Clinical Governance, who will determine whether there is a case for immediate action or a need for inclusion in future Adult Mortality Strategy documents.

**Benchmarking** The Trust is committed to analysing and comparing its performance in activities relevant to adult mortality through a process of benchmarking. Since the Trust runs specialised services, it is acknowledged that the standard benchmarking tools available to most acute adult trusts in the UK may not provide data that are directly applicable to activities at Liverpool Women's Hospital. A working group will therefore be convened to debate and agree upon the best available benchmarking data. The group will consisting of the Associate Medical Director for Clinical Governance, the Clinical Directors for Obstetrics, Gynaecology and Anaesthetics and the Head of Governance. An agreed Adult Mortality Benchmarking Dataset will feature as part of the Adult Mortality Quarterly Report from October 2017 onwards.

## 3.3 Response

**SMART Action Plans** After the analysis of events following an adult death areas of deficiency and opportunities for improvement are presently captured by the production of SMART Action Plans. Similarly, after completion of any clinical audit of relevance to adult death, areas of deficiency and opportunities for improvement are captured by the production of SMART Action Plans.

- specific
- measurable
- agreed
- realistic
- time-based

Each action in a SMART Action Plan has an assigned person responsible for its completion. This may for example be the Safety Lead, the Effectiveness Lead, a senior nurse or midwife or a

manager. Progress against Action Plans is discussed as a routine agenda item at Directorate Clinical Meetings.

The Head of Governance provides oversight and prompts the assigned person responsible if an action is overdue for completion. From April 2017, if a planned action relating to adult mortality has not been completed within one month of its agreed completion date, The Head of Governance will escalate the matter to the Medical Director and the Director of Nursing and Midwifery, who will pursue completion of the action.

When any action in a SMART Action Plan is being closed relating to adult mortality, evidence must be attached to show how the requirements of that action have been met. From May 2017 as an additional measure beyond completion of a SMART Action Plan, the Trust will ensure that full benefit has been achieved by measuring relevant and related clinical outcomes. These outcome measures will be agreed at the Directorate Clinical Meetings and monitored at those same meetings with the assistance of the Head of Governance.

**Quarterly Adult Mortality Report**

The Head of Governance will produce a Quarterly Adult Mortality Report from July 2017 onwards. As a minimum, this report will contain data about:

- number of adult deaths
- number of women who had an Adult Mortality Audit Sheet completed
- number of woman whose death lead to a Root Cause Analysis
- number of deaths attributable to deficiencies in care
- themes identified from the Adult Mortality Audit Sheets and Root Cause Analyses
- actions being taken
- progress against those actions
- outcome measures identified for on-going scrutiny, beyond completion of action plans

In a broader sense, the Quarterly Adult Mortality Report will contain information relevant to all of the activities outlined in this Adult Mortality Strategy, including activities around prevention, analysis, response and bereavement. The Head of Governance will present the Quarterly Adult

Mortality Report to GACA and The Medical Director will present the Quarterly Adult Mortality Report to the public meeting of the Board of Directors, quarterly, to give assurance. A summary of the Quarterly Mortality Reports will also be used by the Head of Governance to populate the Quality Accounts of the Trust from 2018 onwards.

## 3.4 Bereavement

The Macmillan Team provides bereavement support to family and carers after the death of an adult in the Trust. The team comprises six clinical nurse specialists (TWE 4.4), all of whom have advanced communications skills training. They draw upon guidelines from the Cheshire and Merseyside Palliative Care Network to underpin their work,[8] in addition to in-house guidelines that are displayed on the Trust Intranet (Policies Procedures and Guidelines > Gynaecology > general Gynaecology > Bereavement Guideline).

The Trust is committed to putting families and/or carers at the centre of the investigatory process in cases of unexpected adult deaths in gynaecology and all adult deaths in maternity. The Lead Investigator or deputy consults with the bereaved family and/or carers to inform them that an investigation is taking place and notes any questions that they would like addressed. On completion of the investigation, the Lead Investigator or deputy feeds back findings to the bereaved family and/or carers and gives them the opportunity to ask further questions. A copy of the investigatory report is provided to the bereaved family and/or carers at this time. A further opportunity is given to the bereaved family and/or carers to meet with the Lead Investigator or deputy at a later date, once they have had time to consider the content of the investigatory report.

# 4 Learning Disabilities

The Trust recognises that at the present time, there is no agreed approach to the performance of case review after the death of an adult with learning disabilities. The Trust is committed to the production of a Standard Operating Procedure for this circumstance. The work will be lead by the Medical Director and the Head of Adult Safeguarding. It will include a commitment to the use of LeDeR methodology, which is a University of Bristol initiative commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England.[9] The Standard Operating Procedure will be introduced after discussion at the Effectiveness Senate by the end of August 2017.

# 5 Duties and Responsibilities

## 5.1 Individuals

### All Staff

It is the responsibility of all staff to minimise the risk of adult mortality and to minimise its impact. To highlight areas for improvement, the Trust's risk management processes may be used. Issues may also be brought directly to the attention of Safety or Effectiveness Leads, Clinical Directors, senior nursing and midwifery staff, Divisional Managers, the Associate Medical Director for Clinical Governance, the Medical Director or the Director of Nursing and Midwifery for consideration, escalation and action.

### Medical Director

The Medical Director sponsors the Adult Mortality Strategy and has lead responsibility for its delivery. The Medical Director presents the Quarterly Adult Mortality Report to the public meeting of the Board of Directors for assurance. More generally, the Medical Director has joint responsibility for clinical governance in the Trust and with respect to adult mortality, provides the function of 'patient safety director.'

### Non Executive Director

The Non Executive Director who Chairs the meetings of GACA, in conjunction with the Medical Director, takes oversight of the process for reviewing and reporting on adult death in the Trust.

### Director of Nursing and Midwifery

The Director of Nursing and Midwifery has joint responsibility for clinical governance, delegated authority for quality improvement and risk management and is the Executive Lead for infection control. The Director of Nursing and Midwifery supports delivery of the Adult Mortality Strategy.

## Associate Medical Director for Clinical Governance

The Associate Medical Director for Clinical Governance assists the Medical Director and the Director of Nursing and Midwifery in delivering the commitments made in the Adult Mortality Strategy. The Associate Medical Director for Clinical Governance assists the Medical Director and the Director of Nursing and Midwifery in driving up the quality and consistency of clinical governance activities in the Trust.

## Head of Governance

The Head of Governance works with Medical Director, the Director of Nursing and Midwifery and the Associate Medical Director for Clinical Governance, to support delivery of the Adult Mortality Strategy. The Head of Governance produces the Quarterly Adult Mortality Report, presents it to GACA and includes a summary of the Quarterly Adult Mortality Reports in the Trust's Annual Quality Accounts.

## Safety Leads

Safety Leads are usually consultants in the trust, but at the joint request of the Medical Director and the Director of Nursing and Midwifery, senior nursing or midwifery staff can also hold these posts. Safety Leads take responsibility in their own clinical areas for a range of clinical governance activities of relevance to the Mortality Strategy, including the promotion of incident reporting, identifying cases requiring Serious Untoward Incident investigations, ensuring completion of action plans after Serious Untoward Incident investigations, disseminating clinical lessons learnt and co-ordinating responses to national reports or initiatives.

## Effectiveness Leads

Effectiveness Leads are usually consultants in the trust, but at the joint request of the Medical Director and the Director of Nursing and Midwifery, senior nursing or midwifery staff can also hold the posts. Effectiveness Leads take responsibility in their own clinical areas for a range of clinical governance activities of relevance to the Mortality Strategy, including the maintenance of clinical guidelines, formulation and delivery of clinical audit, benchmarking and horizon scanning.

### Senior Managers

Senior managers take a leading role in the management of clinical risks in the Trust, including the management of risks relating to adult mortality. Examples of their responsibilities include escalating clinical risks from the front line, identifying the actions needed to reduce the risk, assigning owners to elements of Action Plans and monitoring mitigating factors.

## 5.2 Committees and Meetings

### Directorate Clinical Meetings

Directorate Clinical Meetings are open to attendance by all medical, nursing and midwifery staff of the relevant directorate. The standing items on their agenda of relevance to the Adult Mortality Strategy include review of the Directorate Risk Register, review of progress against the Clinical Audit Forward Plan, review of the actions detailed in SMART Action Plans after an adult death, review of the actions detailed in SMART Action Plans after a relevant clinical audit, horizon scanning and review of the Quarterly Adult Mortality Report.

### Safety Senate

The Safety Senate monitors themes arising from clinical incidents that have been reported in the Trust, including those that have arisen following an adult death. In addition, after a Serious Untoward Incident, although the Directorate Clinical Meetings monitor progress against the SMART Action Plans produced, the Safety Senate provides monthly oversight and escalates unresolved risks to GACA.

### Effectiveness Senate

The Effectiveness Senate monitors progress against the Trust's Clinical Audit Forward Plan, which includes audit work in those clinical activities most closely related to the risk of adult mortality. In addition, although the Directorate Clinical Meetings monitor progress against the SMART Action Plans produced after their clinical audits, the Effectiveness Senate provides monthly oversight and escalates unresolved risks to GACA.

### Governance and Clinical Assurance Committee

The Governance and Clinical Assurance Committee (GACA) is the sub-committee responsible for providing the Board of Directors with assurance on all aspects of quality of clinical care. GACA therefore oversees clinical governance activity relating to adult mortality. It meets on alternate months and receives, via the Effectiveness Senate and Safety Senate Chairs' Reports, risks relating to adult mortality that have not been resolved at directorate or senate level. In addition, it receives the Quarterly Adult Mortality Report and escalates unresolved risks relating to adult mortality to the Board of Directors. Since the Quarterly Adult Mortality Report is also provided directly to the Board of Directors, which meets monthly, it is accepted that the Board of Directors will occasionally have had sight of an Adult Mortality Quarterly Report before it has been considered by GACA.

### Board of Directors

The Board of Directors meets in public on a monthly basis. It has the overarching responsibility for activities relating to adult mortality in the Trust. It therefore receives the Quarterly Adult Mortality Report for direct consideration. It also receives assurance from GACA with respect to the detailed elements of the report, via the Chair of GACA's Report. In addition, the following items of relevance to adult mortality appear on the Board Assurance Framework: (i) the isolated site of Liverpool Women's Hospital, (ii) transport of adults across the critical care network, (iii) development and support of a comprehensive Clinical Audit Forward Plan, (iv) ensuring that lessons are learnt and change enacted from the reporting and investigation of incidents locally and across the NHS and (v) considering response to NICE Guidance**.**

## 6 Implementation and Monitoring Compliance

An implementation timetable appears as Appendix H to this document. The progress being made against the implementation timetable will be monitored through GACA. Compliance with the commitments made in this strategy document will be monitored via the Quarterly Adult Mortality at GACA and at the Public meeting of the Board of Directors. This strategy will be reviewed and updated annually by the Medical Director.

## 7 Dissemination and Access to the Document

This strategy will available on the Trust intranet from May 2017. All staff will be notified that the strategy is available on the intranet and will be notified by email is any amendments are made at a later date.

## 8 Evidence Base


1. Office for National Statistics, Death registrations summary tables – England & Wales for 2015

2. Learning, Candour and Accountability: a review of the way NHS trusts review and investigate the deaths of patients in England (December 2016). Available online at www.cqc.org.uk

3. National Guidance on Learning from Deaths. National Quality Board (2017) Available at www.england.nhs.uk

4. Need for critical care in gynaecology: a population based analysis. Heinonen S et al (2002). Available online at http://ccforum.com/content/6/4/371

5. Knowing the Risk: a review of peri-operative care of surgical patients (2016). Available at: www.ncepod.org.uk

6. Saving Lives, Improving Mothers' Care. (2016) Available at www.npeu.ac.uk/mbrrace-uk

7. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. Hogan H et al (2012) BMJ Qual Saf 21, 737-745.

8. North West Coast Strategic Clinical Network: Standards and Guidelines (2017). Available at www.cmscnsenate.nhs.uk/strategic-clinical-network/our-networks/palliative-and-end-of-life-care/audit-group/standards/

9. Learning Disabilities Mortality Review (LeDeR) Programme (2017) Available at www.bristol.ac.uk/sps/leder

## Appendix A: Operational Plan 2017-2019

The features of the service enhancements described in the Operational Plan are as follows:

(a) Full Consultant Obstetrician Cover

Twenty-four hour Delivery Suite presence of a Consultant Obstetrician on seven days per week would reduce medical and surgical complication rates and lead to more effective interventions. Full cover would reduce the risk of adult death in the Trust when set against the following causes:

| Cardiac Disease | Sepsis | Thrombosis | Neurological Disease | Psychiatric Deaths | Haemorrhage | Amniotic Embolism | Pre-eclampsia | Early Pregnancy | Anaesthetic Deaths |
|---|---|---|---|---|---|---|---|---|---|
| ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | ✗ | ✗ |

(b) Full Consultant Anaesthetist Cover

Twenty-four hour presence of a Consultant Anaesthetist on seven days per week would allow for the safer provision of anaesthesia and the most effective response to physiological deterioration across a range of obstetric and gynaecological complications. Full cover would reduce the risk of adult death in the Trust when set against the following causes:

| Cardiac Disease | Sepsis | Thrombosis | Neurological Disease | Psychiatric Deaths | Haemorrhage | Amniotic Embolism | Pre-eclampsia | Early Pregnancy | Anaesthetic Deaths |
|---|---|---|---|---|---|---|---|---|---|
| ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ |

(c) Enhanced Consultant Gynaecologist Cover

The twenty-four hour availability of a Consultant Gynaecologist (who is not otherwise engaged in providing elective gynaecological care) would provide support for the optimal management of a full range of life-threatening gynaecological emergencies. Full cover would reduce the risk of adult death in the Trust when set against the following causes:

| Cardiac Disease | Sepsis | Thrombosis | Neurological Disease | Psychiatric Deaths | Haemorrhage | Amniotic Embolism | Pre-eclampsia | Early Pregnancy | Anaesthetic Deaths |
|---|---|---|---|---|---|---|---|---|---|
| ✗ | ✓ | ✗ | ✗ | ✗ | ✓ | ✗ | ✗ | ✓ | ✗ |

(d) Additional Resources for the Management of Gynaecological Cancers

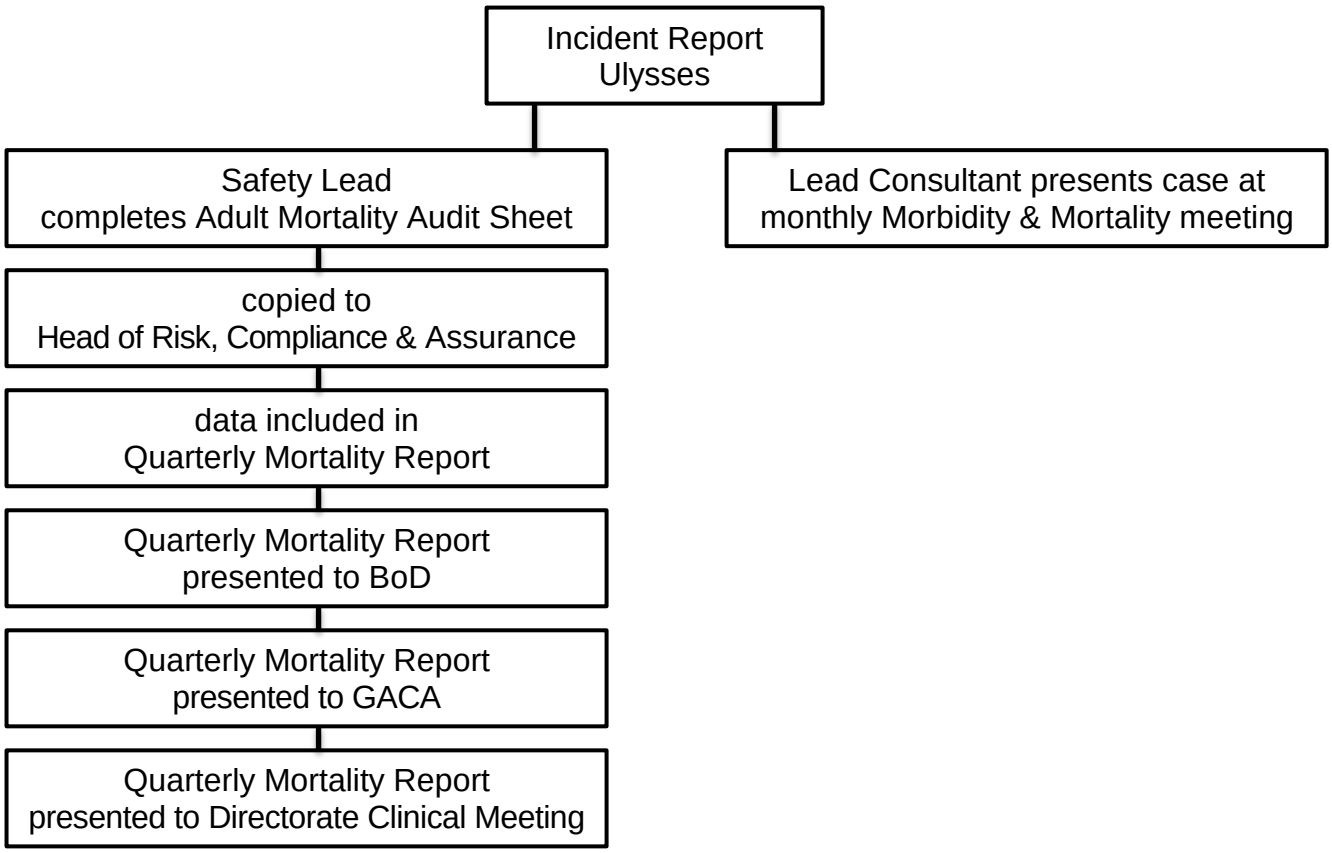
Death from gynaecological malignancy is the commonest cause of adult mortality in the Trust. To minimise this risk, multidisciplinary working is required together with an increased access to the operating theatres and Intensive Care Unit at The Royal Liverpool Hospital. The Business Plan details the following additional resource requirements:

(i) formal SLAs for the services of a colorectal surgeon, a urologist and a radiologist specialising in pelvic disease

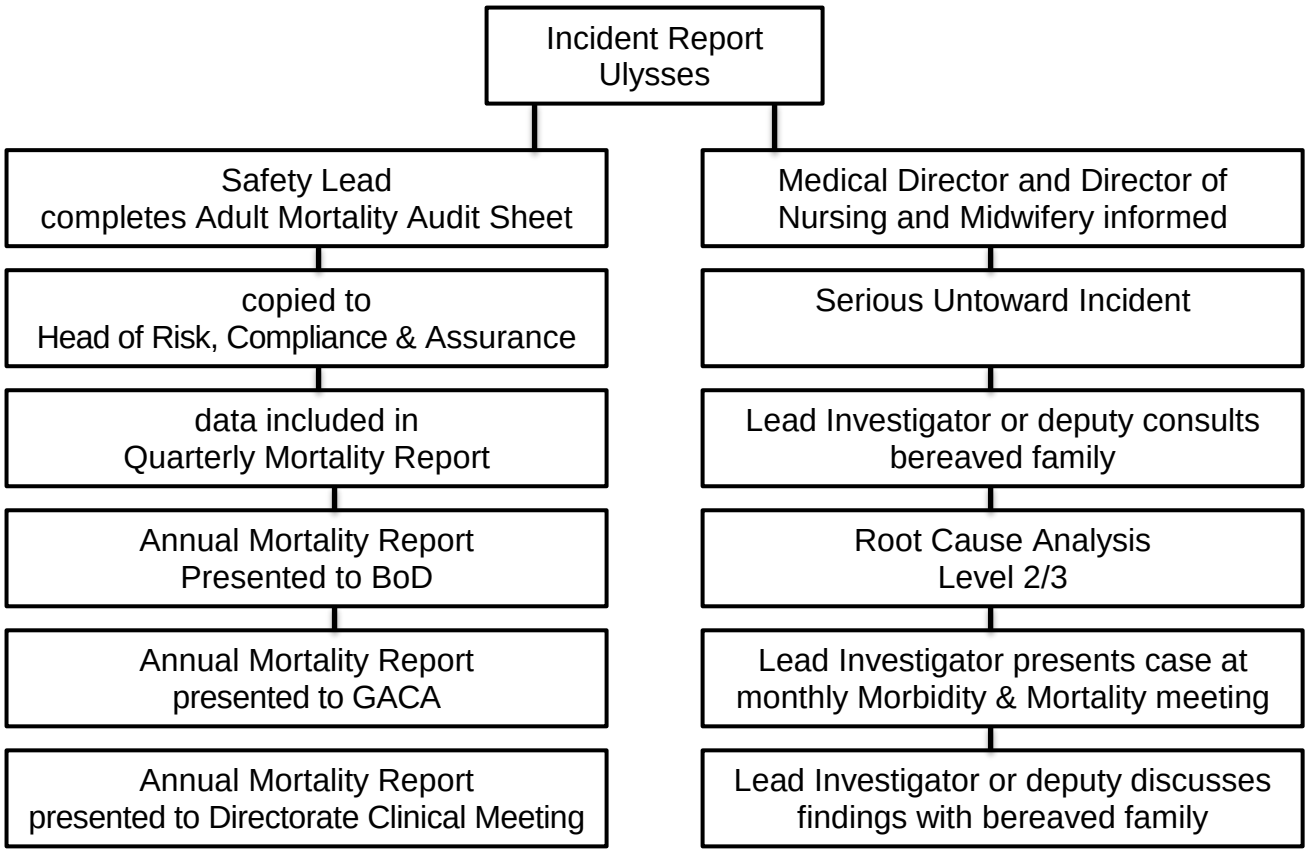
(ii) increased time-allocation for Consultant Gynaecologists to attend Pelvic Cancer MDTs

(iii) weekly operating theatre lists at the Royal Liverpool Hospital.

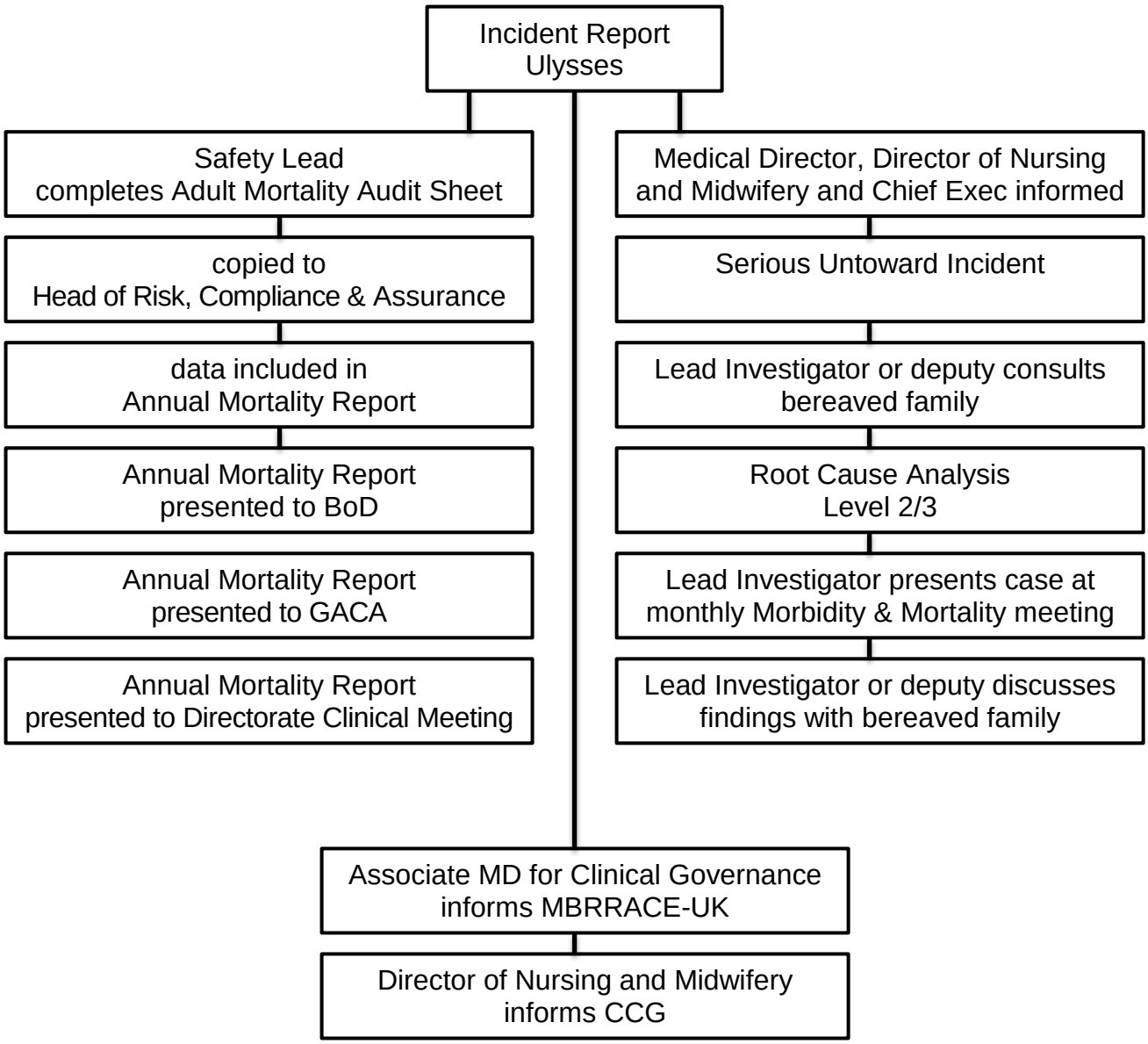
## Appendix B: Response to an Expected Gynaecological Death



## Appendix C: Response to an Unexpected Gynaecological Death



## Appendix D: Response to a Maternal Death



## Appendix E: Adult Mortality Audit Sheet

The content of the Adult Mortality Audit Sheet is as follows:

Date and time of admission:
Date and time of death:
Cause of death 1a: disease or condition directly leading to death
Cause of death 1b: other disease or condition if any, leading to 1a
Cause of death 1c: other disease or condition if any, leading to 1b
Cause of death 2: other significant disease or condition contributing indirectly to death
PM performed: Y/N
Documentation of DNAR in case notes: Y/N
Was the patient on an End of Life Care Pathway: Y/N
Did the patient receive any treatment prior to admission:
Was the patient seen in the emergency department prior to admission:
On initial clerking, were the history and examination appropriate: (If not, specify why)
Was the initial differential diagnosis appropriate: (If not, specify why)
Were the initial investigations (if any) appropriate: (If not, specify why)
Was this an unplanned readmission of a previous discharge?
Time of first review:
Number of hours after admission of first review:
Grade of doctor performing first review:
On first review, were the history and examination appropriate: (If not, specify why)
Was the differential diagnosis on first review appropriate: (If not, specify why)
Were the investigations on first review (if any) appropriate: (If not, specify why)
Time of first Consultant review:
Number of hours after admission of first Consultant review:
Was the NEW score recorded appropriately throughout:
Frequency of observations prescribed:
Clinical deterioration recognised:
Appropriate graded response to deterioration:
Clearly documented medical response to deterioration:
Did the deterioration result in cardiac arrest:
Did the patient receive CPR/resuscitation:
Did the separate location of LWH from an adult acute site contribute to the patient's death:
Did the separate location of LWH from an adult acute site reduce the quality of care provided: (If so, please specify)
Should the patient's management have been handled differently: (If so, please specify)
Are there any lessons to be learnt from this case: (If so, please specify)
Hogan scale:
1 definitely not preventable
2 slight evidence of preventability
3 possibly preventable but not very likely, a little less than 50/50
4 probably preventable but not certain, a little more than 50/50
5 strong evidence of preventability
6 definitely preventable
NCEPOD
1 good practice
2 room for improvement – some clinical care could have been better
3 room for improvement – some organisational care could have been better
4 room for improvement – some clinical & organisational care could have been better
5 less than satisfactory – several aspects of care below an acceptable level
How would you rate the overall quality of care provided by the trust: Excellent / Good / Adequate / Poor / Very poor
Please give a brief clinical resume of the patient:

## Appendix F: Initial Equality Impact Assessment

| **Name of policy/ business or strategic plans/CIP programme:** | **Adult Mortality Strategy v 1.0** | |
|---|---|---|
| **Does the proposal, service or document affect one group more or less favourable than another on the basis of:** | **No** | **Justification/evidence and data source** |
| Age | No | No discrimination / inequality identified, the document sets out the Trust's approach and framework for the management of Adult Mortality, ensuring this is systematic and objective and applied without prejudice or favour. |
| Disability: including learning disability, physical, sensory or mental impairment. | No | |
| Gender reassignment | No | |
| Marriage or civil partnership | No | |
| Pregnancy or maternity | No | |
| Race | No | |
| Religion or belief | No | |
| Sex | No | |
| Sexual orientation | No | |
| **Human Rights – are there any issues which might affect a person's human rights?** | **No** | **Justification/evidence and data source** |
| Right to life | No | No impact on human rights, the document sets out the Trust's approach and framework for the management of Adult Mortality, ensuring this is systematic and objective and applied without prejudice or favour. The aim being to reduce risks to the organisation, its services and the safety and well-being of patients, visitors, staff and the wider public. |
| Right to freedom from degrading or humiliating treatment | No | |
| Right to privacy or family life | No | |
| Any other of the human rights? | No | |

**Assessment carried out by:** **Alan Clark**

**Date:**

**Signature and Job Title:**

## Appendix G: Glossary and Abbreviations

| | |
|---|---|
| **Action** | A response to control or mitigate a risk |
| **Action Plan** | A collection of actions that are specific, measurable, achievable, realistic and targeted. |
| **Board Assurance Framework (BAF)** | A matrix setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available |
| **BoD** | Board of Diorectors |
| **Clinical Audit** | A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit previously stated standards |
| **Corporate Governance** | The system by which Boards of Directors direct and control organisations in order to achieve their objectives |
| **CQC** | Care Quality Commission |
| **Escalation** | Referring an issue to the next appropriate management level for resolution, action, or attention |
| **GACA** | Governance and Clinical Assurance Committee |
| **LeDeR** | Learning Disabilities Mortality Review Programme |
| **MBRRACE-UK** | Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK |
| **NHSLA** | NHS Litigation Authority |
| **NICE** | National Institute for Health and Care Excellence |
| **NPEU** | National Perinatal Epidemiology Unit |
| **RCOG** | Royal College of Obstetrics and Gynaecology |
| **Risk** | The uncertainty of outcome of activity, described as the combination of likelihood and consequence, including perceived importance |
| **Risk Management** | The processes of identifying, assessing & judging risks, assigning ownership, taking actions to mitigate & anticipate them, monitoring and reviewing progress |
| **Risk Register** | A tool for recording identified risks and monitoring actions and plans against them |
| **Strategy** | A document that sets out the corporate approach to a particular area or work activity. This is sometimes described as a policy, particularly outside the NHS |

## Appendix H: Implementation Timetable

| | |
|---|---|
| March 2017 | Agreement of the Clinical Audit Forward Plan at Safety Senate |
| March 2017 | Discussion of the Adult Mortality Strategy at the Executives' Meeting |
| March 2017 | Discussion of the Adult Mortality Strategy at GACA |
| April 2017 | Commencement of data collection using the Adult Mortality Audit Sheet |
| April 2017 | Presentation of the Adult Mortality Strategy to Public Board of Directors |
| May 2017 | Outcome data requirement following completion of SMART Action Plans |
| July 2017 | Draft Adult Mortality Dashboard presented to Effectiveness Senate |
| July 2017 | Presentation of the first Quarterly Mortality Report to GACA |
| July 2017 | Presentation of the first Quarterly Mortality Report to Board of Directors |
| August 2017 | Learning Disabilities SOP / LeDeR presented to Effectiveness Senate |
| August 2017 | Functioning Learning Disabilities SOP / LeDeR in use |
| August 2017 | Functioning Adult Mortality Dashboard in use |
| September 2017 | Clinical Guidelines 95% commitment met |
| October 2017 | Second quarterly report to include adult mortality benchmarking dataset |
| March 2018 | Clinical Audit Forward Plan content relevant to adult mortality completed |
| 2018 | Quarterly Mortality Report summary included in Quality Accounts |

# Perinatal Mortality Strategy

## Liverpool Women's NHS Foundation Trust

**Version 1.0**
**April 2017**

## Contents

# 1 Introduction

Stillbirth is defined as fetal death between the gestation of potential viability and the time of birth. The present rate of stillbirth in the UK is 4.16 per thousand births and in Liverpool, the rate is 5.95. Most stillbirths occur prior to the onset of labour and just over half are unexplained. A UK-wide confidential enquiry into stillbirth conducted in 1997 concluded that a reduction in stillbirths might be achieved if more women were screened for gestational diabetes, the care for women presenting with reduced fetal movements was improved, screening for fetal growth restriction was more widespread and lessons were learned following failures of care. Although stillbirth rates have fallen considerably in the UK since 1997, these themes remain.

Neonatal death is the death of a baby in the 28 days of its life. The present rate of neonatal death in the UK is 1.77 per 1000 live births and in Liverpool, the crude rate is 3.95, driven up by the number of women giving birth in the city whose babies are known to have severe cardiac abnormalities.

Perinatal death is the aggregate of stillbirth and early neonatal death (within the first seven days of life). The programme of national confidential enquiries into perinatal deaths commenced in 1993 with the establishment of the Confidential Enquiry into Stillbirth and Deaths in Infancy (CESDI). This work is now carried out by MBRRACE-UK - a national collaborative programme of work, carried out on behalf of the Healthcare Quality Improvement Partnership. It has surveillance and investigatory functions, focussing on stillbirths, infant and maternal deaths.

The CQC and NHS England recommend that individual NHS trusts should work with their commissioners to review and improve their local approach following the death of people receiving care from their services. Emphasis is given to the need for their Boards to ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated when appropriate and that learning from deaths is shared and acted upon. Engagement with families and carers is also prioritorised in these new national recommendations. Logically, these principles should be applied to not only to adults but also to perinatal deaths. Liverpool Women’s NHS Foundation Trust recognises that although most of the perinatal deaths that it encounters are unavoidable because of the limitations of present technologies, it must seek to understand the causes of perinatal death in its own constituency

and provide services that minimise the risk of such events. In acknowledgement of that fact, the Board of Directors has approved this Perinatal Death Strategy, which is relevant to practice in its maternity and neonatal services.

This strategy is relevant to all of the Trust's clinical staff who are active in its maternity and neonatal services and it is relevant to all of the Trust's managerial staff. The management of perinatal death is a shared responsibility.

## 2 Aim of the Strategy

The aim of this strategy is to set out the Trust's vision for managing perinatal mortality. There are four key elements to be met:

**Prevention** Our aim is to prevent all avoidable perinatal mortality in the Trust.

**Analysis** Our aim is to gather intelligence on all individual instances of perinatal mortality in the Trust, to identify local issues and themes arising from those events, to audit key areas of clinical practice that relate to perinatal mortality and to consider all relevant national documents.

**Response** Our aim is to respond to our analyses by production of SMART Action Plans, including a commitment to seeing those plans through to completion and a commitment to disseminating the intelligence gathered to all relevant clinical and managerial groups. After completion of these action plans we will ensure that full benefit has been achieved by measuring relevant and related clinical outcomes.

**Bereavement** Our aim is to provide bereaved families with an environment tailored to their needs, to raise awareness of the needs of bereaved people amongst our clinical staff and to comply in full with the Duty of Candour in response to perinatal mortality. Bereaved families will form a central part in our investigatory processes when there has been a perinatal death.

## 3 Perinatal Mortality Report

The Trust has been auditing stillbirth since 2004 and in recent years, this has taken the form of a continuous audit published as the Annual Stillbirth Audit. This included information about

stillbirth rates, cause specific conditions and benchmarking data, measuring practice against our expected standards of care. Themes such as obesity, ethnicity, deprivation, reduced fetal movements and growth have been explored in the reports as mini-summaries.

From December 2017, the present stillbirth and early neonatal death audit work will be incorporated into an Annual Perinatal Mortality Report, additional elements of which are described in this strategy document. Production of the Annual Perinatal Mortality Report will be the responsibility of the Associate Medical Director for Clinical Governance in conjunction with the Clinical Directors, Safety and Effectiveness Leads from Maternity and Neonatology and the Trust's Head of Governance. The report will be presented to meetings of GACA, which is a sub-committee of the Board of Directors, in December each year.

# 4 Perinatal Mortality Associations and Causes

Many stillbirths are of unknown cause while some recognised anatomical or physiological abnormalities increase the risk of unavoidable stillbirth or early neonatal death. In other cases, however, the early identification of a problem together with appropriate medical intervention can prevent perinatal death. In the following sections, some of the associations with and causes of perinatal mortality are acknowledged and our Trust-specific responses are described.

## 4.1 Social Deprivation

Liverpool scores below the national average in 26 of the 32 most commonly used indicators for social deprivation, some of which have been illustrated in the table overleaf. This is important to know because both stillbirth and early neonatal death are associated with social deprivation.

It is beyond the reach of the Trust to tackle the root causes of social deprivation in Liverpool but we do acknowledge the role that we have to play in caring for vulnerable pregnant women. We recognise that by providing high quality care, we are reducing the risk of perinatal death, albeit in an unquantified way.

| Social Deprivation Indicator | English Average | Liverpool |
|---|---|---|
| | | |
| Long term unemployment (%) | 9.5 | 19.2 |
| Adults who eat healthily (%) | 28.7 | 23.7 |
| Physically active adults (%) | 56.0 | 52.0 |
| Drug misuse (%) | 8.6 | 16.8 |
| Female life expectancy (years) | 82.9 | 80.1 |
| Smoking in pregnancy (%) | 13.3 | 18.3 |
| Teenage pregnancy (%) | 34.0 | 40.4 |
| Starts breastfeeding after giving birth (%) | 74.8 | 51.2 |

The Trust's response to smoking and obesity have been considered separately later in this strategy document, but in addition:

- We have an active DNA policy
- We run specialised services for women with drug and alcohol problems
- We have a skilled Safeguarding team on-site and all staff receive safeguarding training
- We have redesigned care in the community using an enhanced midwifery model.

These measures have improved access to our services for some of our women at highest risk of experiencing a perinatal death. Our commitment for the future is to consider ways in which we can mitigate the impact of social deprivation whenever any service redesign or reconfiguration is being planned in our maternity or our neonatal services. This will be evidenced through the relevant minuted discussions.

In addition, social deprivation will feature as a key element of a newly developed Annual Perinatal Mortality Report.

The Trust is an academic as well as a clinical institution. We recently contributed to an important national research project called MiNess (a study of lifestyle impact on stillbirth). Our

commitment is to remain at the forefront of research into the impact of lifestyle upon perinatal death.

## 4.2 Smoking

Smoking during pregnancy is associated with stillbirth and a reduction in smoking brings about a reduction in the risk of stillbirth. Pregnant women in Liverpool are more likely to be smokers than pregnant women elsewhere in England. The Trust was an early adopter of the NHS England Saving Babies' Lives Care Bundle, the aim of which is to reduce the incidence of perinatal death. The use of carbon monoxide monitoring to reduce smoking in pregnancy forms part of this care bundle.

The Trust has responded to the risk posed by smoking in pregnancy in the following ways:

- All pregnant women have carbon monoxide testing at their booking appointment
- Women with a high carbon monoxide level are referred to smoking cessation services
- Smoking cessation services are provided on an opt-out rather than an opt-in basis
- SAFOD (smoking at time of delivery) data are submitted to the CCG quarterly.

Our commitment is to carry a prospective audit in 2017-2018, to demonstrate our performance against the above four standards. In addition, smoking will feature as a key element of the Trust's newly developed Annual Perinatal Mortality Report.

## 4.3 Obesity

There is an increased risk of stillbirth in the children of women with a raised BMI and this effect is most marked if the BMI is 35 $kg/m^2$ or more at booking. The phenomenon arises because:

- Placental insufficiency is more likely to occur
- The fetus may face significant metabolic challenges
- Detecting fetal growth restriction or other fetal concerns is more difficult
- Responding to a fetal emergency may take more time because of technical challenges.

In response, Consultant led care is offered to all pregnant women at the Trust who have a BMI of 35 kg/$m^2$ or above at booking, while care in a specialised Bariatric clinic is offered to all women with a BMI 40 kg/$m^2$ or more.

A growing number of previously or presently obese women are presenting to antenatal clinics in the Trust who have undergone bariatric surgery in attempt to lose weight. No national standards exist for the care of these women, who may in some cases have replaced the risks associated with obesity with risks associated with malnutrition. A commitment is now given to review all relevant literature relating to previous bariatric surgery in a pregnant population and to develop a local guideline for practice. The Associate Medical Director for Clinical Governance will give the task of developing this guideline to a Consultant Obstetrician and a ratified guideline will be in place by the end of August 2017.

To monitor the effect of our services, rates of stillbirth for women with a BMI of 35 kg/$m^2$ or more at booking were previously measured and published in an Annual Stillbirth Audit. This audit provided data specific to maternal BMI and was used to indicate whether different forms of treatment or patterns of care might possibly have been of benefit. Maternal obesity will also now feature as a key element of the Trust's newly developed Annual Perinatal Mortality Report.

## 4.4 Pre-existing and Gestational Diabetes

Both stillbirth and early neonatal death are more likely to occur in women who have diabetes, either as pre-existing condition or as a condition that has developed during pregnancy.

Care is provided for women with diabetes at the Trust's Crown Street and Aintree University Hospital sites. In the last year, we have aligned our antenatal management, guidance and documentation across these two sites in order to promote the provision of uniformly high standards of care. Job planning reviews have also been carried out, leading to an increase in the provision of time provided by Consultant Obstetricians to this important area of practice. This has enabled the development of an additional Consultant Led antenatal clinic dedicated to the care of women with gestational diabetes on the Crown Street site.

National standards of care for women with diabetes in pregnancy are provided by NICE. A review of the Trust's practice is currently underway and a revised gap analysis comparing our own services to those described by NICE will be complete by the end of July 2017. This will be presented to the Maternity Divisional Meeting. Where gaps exist, the clinical benefit of service development will be debated and an action plan formulated so that our work towards full compliance can be demonstrated.

In addition, the Trust has participated in the National Diabetes in Pregnancy Audit, which took place between December 2016 and March 2017. This audit will provide local outcome data for our diabetic population, split for the two sites, benchmarked against national outcomes. The audit results will be discussed by a multidisciplinary group of Diabetologist, Obstetricians and Midwives once published. A written response will be produced for local consumption and this will be presented at the Maternity Clinical Meeting by the end of August 2017.

In addition, audit work is planned to determine whether our local standards for practice with respect to steroid administration in women with diabetes are being adhered to. This work forms part of the Trust's Clinical Audit Forward Plan and it will be completed and presented to the Maternity Clinical Meeting by the end of March 2018.

The aim of the Perinatal Mortality Strategy is to prevent all avoidable perinatal mortality in the Trust. The measures highlighted in this section will make a significant contribution to achieving that aim.

## 4.5 Increased Maternal Age

For unknown reasons, the risk of stillbirth is higher in women over the age of 35 than in younger women, the effect is most apparent when a pregnancy has passed its due date and it appears to be independent of the presence of medical co-morbidities, which are more prevalent in older populations.

In a recent study of pregnant women over 35 years of age, inducing labour at 39 weeks rather than continuing to wait for labour did not increase the rate of caesarean section, forceps or

ventouse delivery. It has been suggested, therefore, that 39 week induction could be offered to all women aged 35 years or more as a strategy for reduction the rate of stillbirth.

This is not a nationally accepted recommendation, partly because large extra numbers of women would have to be induced in order to have any impact upon stillbirth rates. The Trust is, however, committed to considering whether age-specific criteria for early induction of labour should be introduced into clinical practice locally. The Clinical Director for Maternity will lead this debate at the Maternity Clinical Meeting and a position statement will be issued on the matter via the minutes of that meeting by the end of September 2017.

## 4.6 Detecting Small for Gestational Age Fetuses

Prolonged placental insufficiency leads to chronic fetal hypoxia. This in turn can restrict fetal growth and may ultimately result in stillbirth. The main intervention available is delivery of the baby but if this is carried out at an unnecessarily early gestation, the complications of extreme prematurity (which can include early neonatal death) may then be encountered.

In 2015, the Trust became an early adopter of the NHS England Saving Babies' Lives Care Bundle, the aim of which was to reduce the incidence of perinatal death. Increased monitoring for growth restricted babies by the use of GROW charts forms part of this care bundle and the Trust has expanded its use of ultrasound for fetal surveillance to match, identifying at risk fetuses and allowing timely intervention. The work is lead by a Consultant in Fetal Medicine at the Trust and by a seconded 'SaBine' Midwife.

As part of an on-going audit relating to the use of the care bundle, the Trust makes regular returns on its performance to NHS England and monitors its own performance through a Perinatal Institute Audit. The audits are presented at Perinatal Mortality and Morbidity Meetings annually and the Maternity Clinical Meetings six monthly. This work will also now feature as a key element of the Trust's newly developed Annual Perinatal Mortality Report.

The Trust is an academic as well as a clinical institution. We recently contributed to an important national research project called Strider ('Sildenafil therapy in dismal prognosis early

onset IUGR). Our commitment is to remain at the forefront of research into the prevention and management of fetal growth restriction.

## 4.7 Response to Reduced Fetal Movements

The Saving Babies' Lives Care Bundle encourages a robust response to the symptom of reduced fetal movements, which has long been associated with stillbirth. Since 2015, the Trust has attempted to raise awareness of reduced fetal movement by including a regionally approved information leaflet in patients' notes. Pathways for the management of reduced fetal movements on the Maternity Assessment Unit have also been enhanced, to include more senior review, additional fetal surveillance by CTG and scanning and in some cases, early induction of labour. These pathways are currently being reviewed by a Maternity Assessment Unit Task and Finish Group, to ensure that best clinical impact is gained from the resources we have available. The work of the group will conclude in May 2017 and any alterations in the management of reduced fetal movements (if any) will be discussed and disseminated through the Maternity Clinical Meeting by the end of July 2017.

Performance against standards for the management of reduced fetal movements is reported to NHS England as part of the Saving Babies' Lives initiative. In-house, the management of reduced fetal movements will be monitored through the use of a newly instituted audit, the findings of which will be reported to the Maternity Clinical Meeting by the end of March 2018.

## 4.8 Fetal Heart Rate Monitoring in Labour

When a woman enters labour with a live fetus but gives birth to a stillborn baby, she is said to have suffered an intrapartum stillbirth. This is a rare event but when it happens, its cause is usually hypoxia (lack of oxygen) resulting from abnormal pressure on the umbilical cord, separation of the placenta from the uterine wall or rupture of the uterus. These same pathologies can also result in the birth of a live but damaged baby and in some cases the damage is so severe that the baby dies in the neonatal period. Any intervention that allows us to pick up fetal hypoxia in labour early enough to intervene before tissue damage has occurred will, therefore, reduce the risk of stillbirth and early neonatal death.

The most common modality for detecting hypoxia in labour is analysis of the fetal heart rate, which is carried out continuously by ‘CTG’ for the highest risk pregnancies and by intermittent auscultation for all others. To be effective, high standards of care in interpreting fetal heart rate patterns are essential.

Effective monitoring of the fetal heart rate in labour formed part of the NHS England Saving Babies’ Lives Care Bundle, previously described. The Trust has also registered with a project called Sign Up To Safety, which is an NHS Litigation Authority initiative aimed at improving fetal heart rate monitoring in labour, and is committed to the aims of the RCOG’s Each Baby Counts initiative, which aims at reducing the toll of damage caused by problems in labour.

To ensure best practice at Liverpool Women’s Hospital, two Sign up to Safety Midwives have been employed by the Trust to promote good practice in fetal heart rate monitoring in labour. Together with Consultant Obstetricians, they run weekly CTG training sessions on the labour ward and during these multidisciplinary sessions, a collated a bank of historical CTG cases are used to highlight important clinical lessons. The Trust is committed to continuing these sessions in the coming year so that the widest possible audience can be reached.

In addition, use of a nationally acclaimed on-line CTG teaching package called K2 has been purchased by the Trust and made available to all of its Obstetricians and Midwives. The Trust now commits to ensuring that 80% of the relevant clinical staff have completed the K2 learning package by the end of December 2017.

At the present time, a Consultant Obstetrician provides direct acute clinical care on-site for thirteen hours each day and or eight hours each day at weekends. The Trust believes that the risk of intrapartum hypoxia would be minimised if Consultant Obstetricians provided 24/7 direct acute clinical care but an additional eight consultants would be required to achieve this level of cover. The Trust’s present commitment, contained in the Operational Plan, is to increase the consultant body by one new consultant per year in the next two years. This will mean that the women whose babies are at highest risk of intrapartum hypoxia are receiving more of their care directly from the most senior members of specialised medical staff in the organisation.

## 4.9 Neonatal Sepsis

It is incumbent upon the health service to provide the highest possible quality of care to newborn babies who have medical needs. The neonatal unit at Liverpool Women's Hospital receives a high volume of babies facing the most severe medical challenges. At the Crown Street site, there are two key areas of concern, both of which may impact upon the risk of early neonatal death. The first relates to deficiencies in the estate. The second relates to the provision of specialised staff.

The current estate is not fit for the purpose of providing neonatal intensive care. There is insufficient floor space for neonatal cots and this increases the risk of life-threatening infection in the first week of life and beyond. To make the estate fit for purpose there will need to be a significant capital outlay and this has been detailed in the financial section of the Trust Operational Plan (2017). The Board of Directors is committed to pursuing this investment in 2017 in order to reduce the risk of neonatal death. The Board of Directors also recognises that in the long term for full risk reduction, a new neonatal rebuild at another suitable site may be required as detailed in the CCG's Future Generations Pre-Consultant Business Case, which considers options for the future location of Liverpool Women's Hospital.

With respect to staffing, the Trust recognises that the current provision of Consultant Neonatologist resident cover falls short of the 12/7 standard recommended by the British Association of Perinatal Medicine (BAPM). An investment in five additional Consultant Neonatologists would be required for this purpose. The present availability of senior trainees in the specialty is low so a step-wise increase in numbers will be required so the Trust's present commitment, contained in the Operational Plan, is to increase the consultant body by one new consultant per year in the next two years. This will mean that the newborn babies at highest risk of death are receiving more of their care directly from the most senior members of specialised medical staff in the organisation.

The Trust also acknowledges that its neonatal nurse staffing levels fall short of BAPM standards, so 1:1 care cannot presently be ensured in the Neonatal Intensive Care Unit. This poses a significant clinical risk so in addition to the consultant expansion described above, expansion of the Advanced Neonatal Nurse Practitioner team by four whole time equivalent

posts forms part of the present strategy. This move will also counter a nationally experienced shortfall in the numbers of neonatologists in training in the medical workforce.

## 5 Bereavement

All women who suffer a perinatal death are offered a full debrief with a consultant. This may be a Consultant Obstetrician, a Consultant Neonatologist or both, depending upon the relevance of each to the clinical circumstances. The debrief includes a discussion about the cause of the perinatal death, its potential avoidability where relevant and the risk of recurrence. After the consultation, a summary of the discussions is provided to the woman in a letter, which also includes a plan for future medical management. If another pregnancy is being planned, pre-pregnancy counselling is also offered at a later date, at a time interval determined by the woman in conjunction with her General Practitioner.

If the woman declines her debriefing opportunity, a letter is provided to her that gives a clinical summary and a plan for future care. The letter also signposts appropriate support for the woman and her family. It is copied to the woman's General Practitioner.

In addition to the medical care described above, the Trust's Honeysuckle Team offer personalised care to all women who have experienced a perinatal loss. This package of care includes elements of psychological support and practical guidance. The Honeysuckle Team run a monthly support group for anyone who has experienced the loss of a baby and they also run a number of other events to provide support for bereaved parents.

All women who have suffered a perinatal loss are offered Consultant led care in future pregnancies. A personalised plan of care is formulated that reflects both her clinical and her psychological needs. At the present time, this care is medically led. The Associate Medical Director for Clinical Governance is currently running a 'Rainbow Babies Initiative' in which the possibility is being considered of extending the Honeysuckle team's involvement in a bereaved woman's future pregnancies, possibly within the format of a newly established Rainbow Babies Antenatal Clinic. Progress against this initiative will be reported to the Maternity Clinical Meeting in August 2017.

The Trust's commitment to providing patients with a positive experience of their care is detailed in the Patient Experience Strategy. The objective of the strategy is to make sure that every member of staff is focussed on the delivery of effective, safe, and personalised care. The Patient Experience Strategy also aims to embed a culture of continuous learning and improvement within the organisation. Since the loss of a baby has devastating impact, adherence to these principles is of paramount importance in this important field of work.

# 6 Investigating a Perinatal Death

## 6.1 Stillbirth

The Trust has a well-embedded process for stillbirth review. The key steps are as follows:

A central register of all stillbirths is kept locally by the Head of Midwifery. The Clinical Coding department sends the Head of Midwifery a monthly update showing all coded stillbirths so that the local list and the external coding data correlate correctly, ensuring that there are no cases being missed from the investigatory process.

All non-fetal abnormality stillbirths are recorded as adverse events using the Trust incident reporting system, Ulysses.

The Clinical Director, Clinical Governance Lead and Head of Midwifery review all stillbirths and agree whether a Serious Incident investigation, formal review or multidisciplinary team review is required. Stillbirths identified as requiring Serious Incident investigations generate a formal report identifying Lessons Leaned and a SMART Action Plan, completion of which is monitored by the Maternity Clinical Meeting. A copy of each report is sent to all staff involved in the delivery of care so that they can be discussed with Educational Supervisors and Supervisors of Midwifery as appropriate. The Lessons Learned are shared more widely via email and at the Maternity Clinical Meetings, in keeping with the Trust's Policy for Managing Incidents and Serious Incidents. A copy of the report is also sent to CCG and the CQC, who may choose to add scrutiny to the event. Importantly, Serious Investigation reports are shared with the woman who has suffered a stillbirth and an opportunity is given for them to discuss the findings will a Consultant Obstetrician.

All Intrapartum stillbirths are declared Serious Incidents and in addition to Serious Investigation reports also undergo review using the Each Baby Counts review process. For these reviews, the Strategic Clinical Network provides an external panel member. The report generated is uploaded on to the Trust shared drive and is shared nationally.

All stillbirths are presently audited using an in-house audit tool and the data generated are presented to the Trust Bi-Annual Perinatal Mortality Meeting. Standards of care in each case are graded according to CESDI criteria.

The Trust has previously published the results of its continuous stillbirth audit as an annual stand-alone report. From December 2017, data generated from this continuous audit and the Lessons Learned and SMART Action Plans generated after Serious Incidents will be included in the Trust's Annual Perinatal Mortality Report.

With respect to benchmarking, the Trust receives yearly figures on its performance through MBRRACE-UK, in which an attempt is made to match local outcomes with national peers. The Trust's Associate Medical Director for Clinical Governance produces a response to the annual MBRRACE-UK report at the time of its publication. This response takes into account local factors that have not otherwise been accounted for in the MBRRACE-UK document. From December 2017, this response will be included in the Trust's Annual Perinatal Mortality Report.

## 6.2 Neonatal Death

MBRRACE suggest that after all neonatal deaths, the Trust providing the clinical care should:

- Conduct a full review of the care provided
- Identify any local factors that might be responsible for high mortality rates
- Establish whether there are lessons to be learned to improve the quality of care.

At Liverpool Women's Hospital, an initial assessment is made immediately after all neonatal deaths (including early neonatal deaths) by neonatal medical and nursing leads, at which time the following questions are asked:

- Does the death meet the threshold for triggering a SUDI investigation? (Sudden Unexplained Death in Infancy)
- Does the death require discussion with the Coroner?
- Does the death require reporting as a Serious Incident?

If the death is a SUDI a police investigation takes place and this has precedence over all other investigatory work. Staff are required to make a written record of their involvement as soon as possible after the event and is converted into a police statement if required.

If the death is not a SUDI but the Coroner decides that a Coroner's Investigation is required, a post mortem examination will normally be carried out on the Coroner's direction. The Trust is provided with the post mortem result only after being given permission by the Coroner and this tends to delay parallel in-house investigations that may be taking place.

If a Serious Incident investigation is required, this can progress at a normal pace unless there is a SUDI, which takes precedence. If there is a Coroner's Investigation taking place in parallel with an in-house Serious Incident investigation, the Trust's investigators will normally reach a preliminary provisional conclusion while waiting conclusion of the Coroner's Investigation and complete their report thereafter. Each Serious Incident report includes a Lessons Leaned section and a SMART Action Plan, completion of which is monitored by the Neonatal Clinical Meeting. Importantly, Serious Investigation reports are shared with the woman who has suffered a neonatal death and an opportunity is given for them to discuss the findings will a Consultant Neonatologist.

In addition to the above, a multi-disciplinary panel of doctors and nurses on the Neonatal Unit use a locally created standardised audit tool to review all neonatal deaths. The aim of these reviews is to agree the cause of death, to determine whether there were any deficiencies in care delivery and to decide whether these deficiencies were likely to have had any causal role in the death. A CESDI code is also determined at this meeting. Learning points arising from these panel reviews are communicated to the wider team by email, at daily handover meetings and at the Neonatal Clinical Meetings.

Selected individual cases are presented to the Trust Bi-Annual Perinatal Mortality Meeting. We select cases that will be of interest to both the neonatal and maternity clinicians who are in attendance at those meetings.

A summary of the data collected from our neonatal death reviews is reported to the Cheshire and Mersey neonatal network Clinical Effectiveness Group (CEG), along with any learning points generated. The Trust has several representatives sitting on the CEG. All deaths are also reported to the local Child Death Overview Panel (CDOP) and are discussed there. One of the neonatal Consultants from this Trust attends the CDOP to inform this discussion and to feed back any relevant points from the discussion to the Neonatal Clinical Meeting.

From December 2017, data generated after SUDIs, Coroner's Investigations and Serious Incidents will be included in the Trust's Annual Perinatal Mortality Report. Lessons learned, SMART Action Plans generated and themes arising from early neonatal deaths will be included in that report.

With respect to benchmarking, the Trust is involved in several ventures in addition to the MBRRACE-UK report:

The Vermont Oxford Neonatal network collects data that allow us to benchmark our very low birthweight and extreme preterm in-hospital mortality against other neonatal units across UK and across the world, with risk adjustment for case mix. This provides reassurance that our mortality rates are within the expected range.

The Quality Account publishes data about neonatal mortality for babies born at the Trust, compared with the national neonatal mortality rates published by the Office for National Statistics, with adjustment for the gestation profile. This provides reassurance that our mortality rates are within the expected range.

The Neonatal Data Analysis Unit also produces an annual report on in-hospital mortality for preterm babies in UK neonatal units. This also provides reassurance that our mortality rates are within the expected range.

The Healthcare Quality Improvement Partnership is presently working with the RCOG and the British Association of Perinatal Medicine to developing a standardised Perinatal Mortality Review Tool (PMRT), for use when investigating perinatal deaths (including early neonatal deaths) and auditing practice. The PMRT is due to be released by the end of December 2017 and after that time the Trust is committed to adopting it for local use. Data generated from use of the PMRT will be included in future editions of the Annual Perinatal Mortality Report together with benchmarking data.

# 7 Duties and Responsibilities

## 7.1 Individuals

### All Staff

It is the responsibility of all staff working in maternity and neonatology to minimise the risk of perinatal mortality and to minimise its impact. To highlight areas for improvement, the Trust's risk management processes may be used. Issues may also be brought directly to the attention of Safety or Effectiveness Leads, Clinical Directors, senior nursing and midwifery staff, Divisional Managers, the Associate Medical Director for Clinical Governance, the Medical Director or the Director of Nursing and Midwifery for consideration, escalation and action.

### Medical Director

The Medical Director has joint responsibility for clinical governance in the Trust and with respect to perinatal mortality, provides the function of 'Patient Safety Director.' The Medical Director works with the Associate Medical Director for Clinical Governance to agree the content of the Perinatal Mortality Strategy and oversees its delivery.

### Associate Medical Director for Clinical Governance

The Associate medical Director for Clinical Governance sponsors the Perinatal Mortality Strategy and has lead responsibility for its delivery. The Associate Medical Director for Clinical Governance presents the Annual Perinatal Mortality Report to GACA and ensures that it is also

discussed and debated at the Maternity and Neonatology Clinical Meetings. More generally, the Associate Medical Director for Clinical Governance assists the Medical Director and the Director of Nursing and Midwifery in driving up the quality and consistency of clinical governance activities in the Trust.

### Non Executive Director

The Non Executive Director who Chairs the meetings of GACA, in conjunction with the Medical Director, takes oversight of the process for reviewing and reporting on perinatal death in the Trust.

### Director of Nursing and Midwifery

The Director of Nursing and Midwifery has joint responsibility for clinical governance, delegated authority for quality improvement and risk management and is the Executive Lead for infection control. The Director of Nursing and Midwifery supports delivery of the Perinatal Mortality Strategy.

### Head of Governance

The Head of Governance works with Associate Medical Director for Clinical Governance, the Medical Director and the Director of Nursing and Midwifery, to support delivery of the Perinatal Mortality Strategy. The Head of Governance assists the Associate Medical Director for Clinical Governance in producing the Annual Perinatal Mortality Report and includes a summary of the Annual Perinatal Mortality Report in the Trust's Annual Quality Accounts.

### Safety Leads

Safety Leads in maternity and neonatology are usually consultants in the trust, but at the joint request of the Medical Director and the Director of Nursing and Midwifery, senior nursing or midwifery staff can also hold these posts. Safety Leads take responsibility in their own clinical areas for a range of clinical governance activities of relevance to the Perinatal Mortality Strategy, including the promotion of incident reporting, identifying cases requiring Serious Untoward Incident investigations, ensuring completion of action plans after Serious Untoward

Incident investigations, disseminating clinical lessons learnt and co-ordinating responses to national reports or initiatives. In conjunction with their Clinical Directors and the Effectiveness Leads, they assist the Associate Medical Director for Clinical Governance in producing the Annual Perinatal Mortality Report.

### Effectiveness Leads

Effectiveness Leads in maternity and neonatology are usually consultants in the trust, but at the joint request of the Medical Director and the Director of Nursing and Midwifery, senior nursing or midwifery staff can also hold the posts. Effectiveness Leads take responsibility in their own clinical areas for a range of clinical governance activities of relevance to the Perinatal Mortality Strategy, including the maintenance of clinical guidelines, formulation and delivery of clinical audit, benchmarking and horizon scanning. In conjunction with their Clinical Directors and the Safety Leads, they assist the Associate Medical Director for Clinical Governance in producing the Annual Perinatal Mortality Report.

### Senior Managers

Senior managers take a leading role in the management of clinical risks in the Trust, including the management of risks relating to perinatal mortality. Examples of their responsibilities include escalating clinical risks from the front line, identifying the actions needed to reduce the risk, assigning owners to elements of Action Plans and monitoring mitigating factors.

## 7.2 Committees and Meetings

### Directorate Clinical Meetings

Directorate Clinical Meetings are open to attendance by all medical, nursing and midwifery staff of the relevant directorate. The standing items on their agenda of relevance to the Perinatal Mortality Strategy include review of the Directorate Risk Register, review of progress against the Clinical Audit Forward Plan, review of the actions detailed in SMART Action Plans, horizon scanning and review of the Annual Perinatal Mortality Report.

## Safety Senate

The Safety Senate monitors themes arising from clinical incidents that have been reported in the Trust, including those that have arisen following a perinatal death. In addition, after a Serious Untoward Incident, although the Directorate Clinical Meetings monitor progress against the SMART Action Plans produced, the Safety Senate provides monthly oversight and escalates unresolved risks to GACA.

## Effectiveness Senate

The Effectiveness Senate monitors progress against the Trust's Clinical Audit Forward Plan, which includes audit work in those clinical activities most closely related to the risk of perinatal mortality. In addition, although the Directorate Clinical Meetings monitor progress against the SMART Action Plans produced after their clinical audits, the Effectiveness Senate provides monthly oversight and escalates unresolved risks to GACA.

## Governance and Clinical Assurance Committee

The Governance and Clinical Assurance Committee (GACA) is the sub-committee responsible for providing the Board of Directors with assurance on all aspects of quality of clinical care. GACA therefore oversees clinical governance activity relating to perinatal mortality. It meets on alternate months and receives, via the Effectiveness Senate and Safety Senate Chairs' Reports, risks relating to perinatal mortality that have not been resolved at directorate or senate level. In addition, it receives the Annual Perinatal Mortality Report and escalates unresolved risks relating to perinatal mortality to the Board of Directors.

## Board of Directors

The Board of Directors meets in public on a monthly basis. It has the overarching responsibility for activities relating to perinatal mortality in the Trust. It receives assurance from GACA with respect to the detailed elements of the Annual Perinatal Mortality Report, via the Chair of GACA's Report.

## 8 Implementation and Monitoring Compliance

An implementation timetable appears as Appendix C to this document. The progress being made against the implementation timetable will be monitored through GACA. Compliance with the commitments made in this strategy document will be monitored via the Annual Perinatal Mortality Report at GACA. This strategy will be reviewed and updated annually by the Associate Medical Director for Clinical Governance.

## 9 Dissemination and Access to the Document

This strategy will available on the Trust intranet from May 2017. All staff will be notified that the strategy is available on the intranet and will be notified by email is any amendments are made at a later date.

## Appendix A: Initial Equality Impact Assessment

| **Name of policy/ business or strategic plans/CIP programme:** | **Perinatal Mortality Strategy v 1.0** | |
|---|---|---|
| **Does the proposal, service or document affect one group more or less favourable than another on the basis of:** | **No** | **Justification/evidence and data source** |
| Age | No | No discrimination / inequality identified, the document sets out the Trust's approach and framework for the management of Adult Mortality, ensuring this is systematic and objective and applied without prejudice or favour. |
| Disability: including learning disability, physical, sensory or mental impairment. | No | |
| Gender reassignment | No | |
| Marriage or civil partnership | No | |
| Pregnancy or maternity | No | |
| Race | No | |
| Religion or belief | No | |
| Sex | No | |
| Sexual orientation | No | |
| **Human Rights – are there any issues which might affect a person's human rights?** | **No** | **Justification/evidence and data source** |
| Right to life | No | No impact on human rights, the document sets out the Trust's approach and framework for the management of Adult Mortality, ensuring this is systematic and objective and applied without prejudice or favour. The aim being to reduce risks to the organisation, its services and the safety and well-being of patients, visitors, staff and the wider public. |
| Right to freedom from degrading or humiliating treatment | No | |
| Right to privacy or family life | No | |
| Any other of the human rights? | No | |

**Assessment carried out by:** **Alan Clark**

**Date:**

**Signature and Job Title:**

## Appendix B: Glossary and Abbreviations

| | |
|---|---|
| **Action Plan** | A collection of actions that are specific, measurable, achievable, realistic and targeted. |
| **BAF** | Board Assurance Framework - a matrix setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available |
| **BAPM** | British Association of Perinatal Medicine |
| **BoD** | Board of Directors |
| **CESDI** | Confidential Enquiry into Stillbirth and Death in Infancy |
| **Clinical Audit** | A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit previously stated standards |
| **Corporate Governance** | The system by which Boards of Directors direct and control organisations in order to achieve their objectives |
| **CQC** | Care Quality Commission |
| **Escalation** | Referring an issue to the next appropriate management level for resolution, action, or attention |
| **GACA** | Governance and Clinical Assurance Committee |
| **MBRRACE-UK** | Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK |
| **NHSLA** | NHS Litigation Authority |
| **NICE** | National Institute for Health and Care Excellence |
| **NPEU** | National Perinatal Epidemiology Unit |
| **RCOG** | Royal College of Obstetrics and Gynaecology |
| **Risk** | The uncertainty of outcome of activity, described as the combination of likelihood and consequence, including perceived importance |
| **Risk Management** | The processes of identifying, assessing & judging risks, assigning ownership, taking actions to mitigate & anticipate them, monitoring and reviewing progress |
| **Risk Register** | A tool for recording identified risks and monitoring actions and plans against them |
| **Strategy** | A document that sets out the corporate approach to a particular area or work activity. This is sometimes described as a policy, particularly outside the NHS |
| **VON** | Vermont Oxford Network |

## Appendix C: Implementation Timetable

| | |
|---|---|
| May 2017 | Maternity Assessment Unit (MAU) Task and Finish Group report published |
| July 2017 | MAU report discussed at Maternity Clinical Meeting (MCM) |
| July 2017 | Gap analysis for NICE Diabetes in Pregnancy Guideline repeated |
| August 2017 | National Diabetes in Pregnancy Audit response to MCM |
| August 2017 | Management of Pregnancy after Bariatric Surgery Guideline ratification |
| August 2017 | Report on Rainbow Babies Antenatal Clinic initiative to MCM |
| September 2017 | Position Statement on management of increased maternal age in pregnancy |
| December 2017 | Annual Perinatal Mortality Report to GACA |
| December 2017 | Prospective audit on smoking in pregnancy completion |
| December 2017 | K2 80% standard reached for CTG training in clinically relevant personnel |
| March 2018 | Audit on reduced fetal movements completion |
| March 2018 | Introduction of national Perinatal Mortality Review Tool |
| March 2018 | Audit on steroid administration in pregnant women with diabetes completion |

| | |
|---|---|
| **Agenda item no:** | 2017/123 |

| | |
|---|---|
| **Meeting:** | Board of Directors |

| | |
|---|---|
| **Date:** | 5th May 2017 |

| | |
|---|---|
| **Title:** | Guardian of Safe Working Hours Report |

| | |
|---|---|
| **Report to be considered in public or private?** | Public |

| | |
|---|---|
| **Purpose - what question does this report seek to answer?** | The purpose of this report is to meet the Guardian of Safe Working Hours reporting requirements as laid down in the new junior doctor contract 2016. |

| | |
|---|---|
| **Reference/s:** | Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016<br><br>Exception Reporting Policy |

| | |
|---|---|
| **Resource impact:** | |

| | |
|---|---|
| **What action is required at this meeting?** | The Board is asked to acknowledge the information enclosed within this report. |

| | |
|---|---|
| **Presented by:** | Mr Geoff Shaw – Guardian of Safe Working Hours |

| | |
|---|---|
| **Prepared by:** | Rochelle Collins, Medical Staffing Manager |

This report covers (tick all that apply):

| **Strategic objectives:** | |
|---|---|
| To develop a well led, capable and motivated workforce | √ |
| To be efficient and make best use of available resources | √ |
| To deliver safe services | √ |
| To deliver the most effective outcomes | |
| To deliver the best possible experience for patients and staff | √ |

| **Other:** | | | |
|---|---|---|---|
| Monitor compliance | | Equality and diversity | |
| NHS constitution | | Integrated business plan | |

| | | | |
|---|---|---|---|
| | | | |

| **Which standard/s does this issue relate to:** | |
|---|---|
| Care Quality Commission | |
| Clinical Negligence Scheme for Trusts | |
| NHS Litigation Authority | |

| **Publication of this report** (tick one)**:** | |
|---|---|
| This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedom of Information Act 2000, because such disclosure might constitute a breach of confidence | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust | |

## 1. Introduction

As part of the Terms & Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 that was implemented nationally on 5th October 2016, there is a requirement in Schedule 6 for the appointment of a Guardian of Safe Working Hours. There is also a requirement for this role to report to the appropriate Board / Sub-Board on a quarterly basis.

## 2. Background

The new contract highlights three functions which oversee the safety of doctors in the training and service delivery domains of their working experience:

a. The employer or host organisation designs schedules of work that are safe for patients and safe for doctors, and ensures that work schedules are adhered to in the delivery of services.

b. The Director of Medical Education (DME) oversees the quality of the educational experience.

c. The Guardian of Safe Working Hours provides assurances to the employer, and host organisation if appropriate on the compliance with safe working hours by the employer and the doctor.

The Guardian of Safe Working Hours is a new role created as part of the 2016 contract. The Trust appointed Mr Geoff Shaw (Consultant Obstetrician) to the role in July 2016.

The role of the Guardian is to;

- Act as a champion of safe working hours
- Record and monitor compliance of exception report management and review cases escalated by a doctor in training
- Escalate issues for action where not addressed locally
- Will request work schedule reviews to be undertaken where necessary
- Oversea safety-related exception reports and monitor compliance with the system
- Intervenes as required to mitigate safety risks
- Intervenes where issues are not being resolved satisfactory
- Provide assurances on safe working and compliance with TCS
- Submits a quarterly report to the Trust Board on the functioning of the contract and exception reporting

The Guardian is responsible to the Medical Director and should not be involved in management roles within the Trust, but have a fully independent role with access to the Board as required.

## 3. Reporting Requirements

The 2016 contract requires the Guardian to report to the Trust Board / Sub Board Committee on a quarterly basis, with the following information;

- Aggregated exception reports including outcomes
- Details of fines levied
- Data on rota gaps
- Data on locum usage
- Other relevant data
- Qualitative narrative highlighting areas of good practice or persistent concern

## 4. Context of Reporting Requirements

4.1 Schedule of Implementation of the new Contract:

By way of context, there is only a small number of junior doctors on / due to transfer to the new contract in 2017/18 based on the national implementation schedule. The table below details this:

| Date | Grade | No: of Doctors | Speciality |
|---|---|---|---|
| December 2016 | FY 1 | 2 | O&G |
| March 2017 | ST 1 | 5 | Neonates |
| March 2017 | ST 6 | 1 | Neonates |
| August 2017 | FY 2 | 2 | O&G |
| August 2017 | ST1 | 5 | O&G |
| August 2017 | ST2 | 4 | O&G |
| August 2017 | GPST1 & GPST2 | 12 | O&G |
| August 2017 | CT2 | 4 | Anaesthetics |
| August 2017 | ST3 | 4 | Anaesthetics |
| August 2017 | ST3 | 3 | Clinical Genetics |
| August 2017 | ST2 | 4 | Neonates |

As such, the Guardian of Safe Working Hours reporting is only based on those doctors on the new contract. At the time of the production of this report, there are 8 junior doctors on the new contract.

4.2 Rota Reporting:

Under the new contract, there is a requirement for an annual report to the Board / Sub Board Committee on rota gaps and any subsequent action plans to fill these gaps.

By way of context, the Trust hosts 8 rotas for a number of different grades of doctors across 4 specialties. The rotas are compliant with the 2002 and 2016 contracts. This has been achieved using the nationally recognised Doctors Rostering System (DRS).

4.3 Exception Reporting:

Exception reporting is the mechanism used by doctors in training to inform their employer / host when their day-to-day work varies significantly and / or regularly from the agreed work schedule. Primarily these variations will be:

- differences in the total hours of work (including opportunities for rest breaks)
- differences in the pattern of hours worked
- differences in the educational opportunities and support available to the doctor, and / or
- differences in the support available to the doctor during service commitments

Exception reporting is a requirement of the 2016 contract and the DRS system allows such reports to be submitted by doctors in training.

It is the role of the Guardian of Safe Working Hours to monitor and oversee exception reports and enabling them to address higher level issues.

**5. Guardian Report**

5.1 Aggregated exception reports including outcomes

The Trust has received 4 exception reports over the last 4 months. All 4 reports were resolved locally between the doctor and the Educational Supervisor. The Doctor requested time back in lieu which was accommodated. The Trust expects the number of exception reports submitted to increase as the number of doctors moving onto the new contract also increases.

5.2 Details of fines levied

To date, the Guardian has not issued any fines as all issues have been resolved locally and a fine therefore not required.

5.3 Data on rota gaps

Due to the known national shortage of junior doctors, and as detailed on the Trust Risk Register, the Trust usually runs with a number of gaps on the rotas across all services. The majority of these gaps are in the main covered by locum shifts from the current cohort of doctors in training. However, there is an increasing reliance on agency locum shifts in in O&G, managed within the current framework agreement. The table below shows the number of gaps on rotas during this rotation period:

| Speciality | No: of gaps |
|---|---|
| O&G | 6.5 |
| Neonates | 2 |
| Anaesthetics | 2 |
| Genetics | 1 |

For note, due to the national shortage of junior doctors, it is becoming increasingly difficult to recruit to posts within the junior doctor workforce across all specialities so it is envisaged that rota gaps will continue and may even increase.

5.4 Data on locum usage

The number of shifts covered by a locum doctor over the period of the last 6 months is detailed below by month and specialty:

| Month | O&G | Neonates | Anaes | Genetics |
|---|---|---|---|---|
| Oct 2016 | 20 | 0 | 0 | 0 |
| Nov 2016 | 36 | 0 | 0 | 0 |
| Dec 2016 | 48 | 3 | 11 | 0 |
| Jan 2017 | 60 | 2 | 7 | 0 |
| Feb 2017 | 43 | 2 | 8 | 0 |
| Mar 2017 | 40 | 5 | 19 | 0 |

Nb. of the 247 locum shifts within O&G, 36 of these shifts were covered by agency locums within the agreed capped rates. All other locum shifts in both O&G and the other specialties were covered by the current junior doctor cohort undertaking additional shifts.

5.5 Other relevant data

There are no other issues, concerns or particular data sets to report at this point.

5.6 Qualitative narrative highlighting areas of good practice or persistent concern

The main area of concern for the Trust is the theatre overruns. If this trend of theatre overruns continues, the Trust may experience an increase in exception reports and an introduction of fines. This has been addressed with the Clinical Director for Gynaecology and will be looked at in conjunction with the current theatre review.

**Next Steps**

Moving forward into the first full year of the junior doctor contract implementation, the focus will be on the following;

- Continue to engage with Doctors in Training
- Ensure all educational supervisors are fully trained in exception reporting
- Ensure all work schedules are completed within the agreed timescales
- Continue to monitor exception reports and resolve as appropriate
- Continue to manage rota gaps and escalate as appropriate
- Devise a fine system and embed within the organisation

**Recommendations**

The Board is asked to receive assurance that the role of the Guardian of Safe Working Hours is ensuring that the doctors are safely rostered and enabled to work hours that are safe and in compliance with their contract.

**Performance and Information Department**
**Performance Team**

| | |
|---|---|
| **Agenda Item No:** | 2017/124 |
| **Meeting:** | Trust Board |
| **Date:** | April 2017 |
| **Title:** | Performance Dashboard - Month 12 - March 2017 |
| **Report to be considered in Public or Private?** | Public |
| **Where else has this report been considered and when?** | Performance Group, Trust Management Group, Finance, Operations Board, Finance, Performance and Business Development Board |
| **Reference/s** | Quality Strategy, Quality Schedule, CQUINS, Corporate Performance Indicators, Monitor Assurance Framework |
| **Resource impact:** | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **What is this report for?** | **Information** | | **Decision** | | **Escalation** | | **Assurance** | |

| | |
|---|---|
| **Which Board Assurance Framework risk(s) does this report relate to?** | 1. Deliver safe services<br>3. Deliver the best possible experience for patients and staff<br>4. To develop a well led, capable and motivated workforce<br>5 to be ambitious and efficient and make best use of available resources |
| **Which CQC fundamental standard(s) does this report ralet to?** | Good Governance<br>Staffing<br>Safety<br>Complaints |
| **What action is required at this meeting?** | To Note |
| **Presented by:** | Jeff Johnson |
| **Prepared by:** | David Walliker |

This report covers (tick all that apply):

| **Strategic objetives:** | |
|---|---|
| To develop a well led, capable, motivated and entrepreneurial **workforce** | ✓ |
| To be ambitious and **efficient** and make best use of available resources | ✓ |
| To deliver **safe** services | ✓ |
| To participate in high quality research in order to deliver the most **effective** outcomes | ✓ |
| to deliver the best possible **experience** for patients and staff | ✓ |

**Other:**

| | | | | |
|---|---|---|---|---|
| Monitor Compliance | ✓ | | Equality and diversity | |
| NHS Constitution | | | Integrated business plan | |

**Publication of this report** (tick one):

| | | |
|---|---|---|
| This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting. | | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedomn of Information Act 2000, because the information contained is reasonable accessible by other means. | | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedomn of Information Act 2000, because the information contained is intended for future publication. | | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedomn of Information Act 2000, because such disclosure might constitute a breach of confidence. | | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedomn of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust. | | |

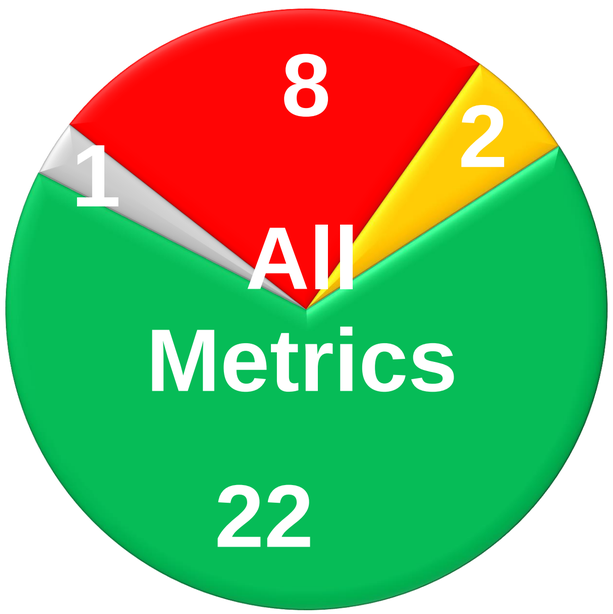
**1. Introduction and summary**

**2. Issues for consideration**

**3. Conclusion**

**4. Recommendation/s**

# Performance Report - Trust Board — Month 12 - March 2017








# Performance Summary - Trust Board - Month 12 - March 2017

## Overview

Of the 33 KPI's RAG rated in the Trust Board Dashboard for March 2017, 22 are rated Green, 8 are rated Red and 2 are rated as Amber. The figure for Choose and Book is not yet available nationally.

The KPI's rated as Red for March 2017 are:

- 3 x Finance KPI's reported separately via the Finance Report
- HR: Sickness & Absence Rate at 5.71% against a target of <= 4.5%
- Women seen by a midwife within 12 weeks at 87% against a target of 90%
- Women that requested and Epidural, but weren't given one for non-clinical reasons at 7.09% against a target of <= 5%
- 6 Week Wait for Diagnostic Tests at 98.8% against a target of >= 99%
- Maternity Triage within 30 Minutes at 85.45% against a target of >= 95%

The KPIs rated as Amber for March 2017 are:

- HR: Appraisals & PDR at 86% against a target of >= 90%
- HR: Mandatory Training at 90% against a target of >= 95%

To view the Full TMG/FPBD version of the Performance Dashboard double click the PDF icon to the right.

Performance Dashboard TMG& FPBD - March 2017

# Performance Summary - Trust Board - Month 12 - March 2017

## To develop a well led, Capable, Motivated and Entrepreneurial WORKFORCE


### HR: Sickness & Absence Levels at 5.71% against a target of <= 4.5%

The overall single month sickness figure increased marginally by 0.15% from 5.56% in month eleven to 5.71% in month twelve. This is currently 2.21% above the Trust target figure of 3.5%, and therefore rated as red. The cumulative figure increased from 4.91% to 4.96%.

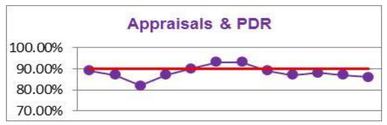
Managers are continuing to work closely with their HR teams to ensure that individual cases are managed appropriately, that staff are managed on the appropriate stages and that staff are supported in returning to work as soon as is appropriate.

The Human Resources Department provide detailed absence information and advice to support managers in addressing sickness absence. They also provide training to new and existing managers in how to effectively manage sickness absence.

Support for managers is also provided by Occupational Health, particularly in terms of advice for supporting staff off long term in returning to work. The operations team are currently undertaking an audit of return to work interviews.

A document was recently circulated to managers reminding them of their responsibilities in relation to managing sickness absence. A similar document is now being put together for circulation to all staff covering the individual's responsibilities in relation to sickness absence.

The HR department are currently working on a series of 'lunch and learn' training sessions which will be open to all managers. These are being developed as 'bite-size' learning sessions that will cover a range of different subjects, including a number of sessions on different aspects of attendance management.




### HR: Appraisals & PDR Rates at 86% against a target of >= 90%

The overall Trust compliance rate for PDRs fell marginally by 1% from 87% in month eleven to 86% in month twelve. This is now 4% under the Trust's target rate of 90% and therefore rated as amber.

The L&D and HR teams continue to provide detailed information to managers with regards to PDR compliance in their areas of responsibility. On-going workshops are scheduled for managers and reviewers.

Managers are required to have plans in place to ensure that compliance targets are met and maintained, and these are regularly reviewed and updated.

In Gynae, the new interim Matron is meeting with ward managers to ensure that plans are in place to bring compliance rates up to target.

In Transport, The department manager has recently left the Trust, and the service is about to transfer over to CMFT. Transitional management arrangements are in place for CMFT Managers to support the service, but it is unlikely that compliance rates will change significantly before the transfer in June.


### HR: Mandatory Training Rates at 90% against a target of >= 95%

In month twelve, the overall Trust figure for mandatory training compliance remained unchanged at 90%. This is 5% below the Trust's target figure of 95% and is therefore rated as amber.

The Learning & Development and Human Resources teams provide managers at all levels with detailed information regarding mandatory training compliance.

All ward and department managers are required to have appropriate plans in place to ensure that compliance rates are reached and maintained, and these are reviewed and updated each month.

There have been on-going issues with the provision of conflict resolution training and ILS training. For conflict resolution, refresher courses have now been scheduled, and work in underway to train internal trainers to be able to deliver training for new starters. For ILS, options are currently being looked at to buy in this training from external providers.

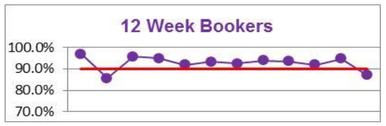
All Linear graphs are rolling 12 months

# Performance Summary - Trust Board - Month 12 - March 2017

## To be EFFICIENT and make best use of available resources

**Financial Report will be provided separately (3 x Red KPIs)**

## To deliver SAFER services




**Women seen by a midwife within 12 weeks is at 87% against a target of 90%.**

Some of the women who have booked late recently have seemed to be unaware of the early access process available at Liverpool Women's and have waited for GP appointments rather than direct access. Team leaders report less than usual communication for EA team regarding slot utilisation for bookings which may result in women waiting longer for booking appointments.

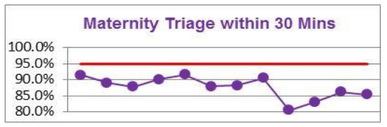
Refresh information available to women in GP practices, children's centres and other appropriate venues informing women of early access process
Matron to discuss non-compliance with early access manager to identify any issues with capacity and booking slot utilisation.

## To deliver the most EFFECTIVE outcomes

**There are no Red or Amber rated KPIs in this section**

# Performance Summary - Trust Board - Month 12 - March 2017

## To deliver the best possible EXPERIENCE for patients and staff

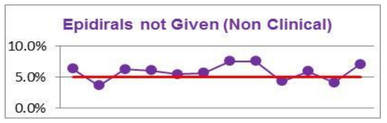



**Maternity Triage within 30 minutes at 85.45% against a target of >= 95%**

There were 1152 women seen in MAU during the month of March 2017, of these women there were 137 breaches. This KPI was arbitrarily set some time ago when there was no traffic light system for prioritisation of the cases attending MAU. There is no Maternity standard or national guidance on which to base the 30 minute target. The type of admission to MAU and the use of telephone triage were not taken into account. It does not also take into account the changes made in MAU since the introduction of the target – presence of Band 7 shift leader; increase in Consultant cover; the traffic light system for prioritisation.

It has become apparent, following review of the last 12 months figures, that a blanket target of 30 minute triage for all who attend MAU is not appropriate. Those labelled low risk 'green' need a different pathway from those urgent cases labelled 'red'.

The Division has a plan in place to set an appropriate target which accounts for the changes in the flow through of patients in MAU. The MAU task and finish group (chaired by Professor Alfirevic) is currently looking at case mix attending MAU and fine tuning the pathways and prioritisation methodology. This group will also advise on the appropriate targets for triage for the different groups. It is expected that there will be different thresholds depending on:Whether telephone triage has already been undertaken
Urgency of the case (red, amber, green)



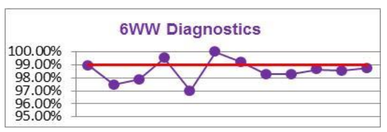

**Women that requested and Epidural, but weren't given one for non-clinical reasons is at 7.09% against a target of 5%**

145 Women requested Epidural for their chosen analgesia out of these

17 women were in advanced labour and therefore it was not clinically appropriate, another 4 were not provided with an epidural as a result of patient factors. There were an additional 4 patients who had unsuccessful attempts

2 women did not receive an epidural due to lack of available beds on delivery suite. This was due to high activity and unavailability of postnatal beds during the month of March and 4 due to the unavailability of a
midwife

This KPI has previously been highlighted as an area for review and the directorate are reviewing the recording and the differentiation between clinical and non clinical reasons. It is envisaged that once the definitions are clearly identified and agreed the KPI will be achieved




**6 Week Diagnostic Waits at 98.8% against a target of >= 99%**

Ongoing pressures with the availability of consultant led cystometry appointments, coupled with annual leave of nurse specialists has seen an increased pressure with cystometry sessions within this service, resulting in a 8 breaches within month..

Consultant cystometry requests are being reviewed by the nursing staff to see if referrals can be converted to nurse led. This allows additional clinics to be arranged, if possible, to ensure capacity is available to meet current demand

All Linear graphs are rolling 12 months

# Performance Summary - Trust Board - Month 12 - March 2017

## Emerging Concerns

See CQUINS in FPBD

## Conclusion

Overall, for March 2017 performance has slightly declined in comparison to February 2017. However, most of the KPI's where the targets have not been attained have been prevalent throughout the year. These include the HR KPIs along with Maternity Triage, Diagnostic Waits , and Malnutrition Care Plans.

It is anticipated that overall performance may improve  once all CQUIN evidence have been reviewed and submitted taking the overall percentage of green indicators to 76.86%

## Recommendations

It is recommended that the Trust Board receives and reviews the content of the report in relation to the assurance it provides of Trust performance and request any further actions considered necessary.

Liverpool Women's NHS Foundation Trust

# LWH - The Board Report 2016/17

Key: TBA = To Be Agreed. TBC = To Be Confirmed, TBD = To Be Determined, ID = In Development

## To develop a well led, Capable, Motivated and Entrepreneurial WORKFORCE

| Indicator Name | Ref | Target | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff Friends & Family Test (PULSE) | | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant |
| HR: Sickness & Absence Rates (Commissioner) | | <= 4.5% | 4.42% | 3.51% | 3.05% | 3.09% | 4.61% | 5.03% | 5.16% | 5.88% | 6.32% | 5.92% | 5.56% | 5.71% |
| HR: Annual Appraisal and PDR | | >= 90% | 89.00% | 87.00% | 82.00% | 87.00% | 90.00% | 92.00% | 90.00% | 89.00% | 87.00% | 88.00% | 87.00% | 86.00% |
| HR: Completion of Mandatory Training | | >= 95% | 92.00% | 94.00% | 94.00% | 94.00% | 93.00% | 93.00% | 93.00% | 93.00% | 92.00% | 91.00% | 90.00% | 90.00% |
| HR: Turnover Rate | | <= 10% | 11.00% | 13.00% | 13.00% | 14.00% | 16.00% | 14.00% | 14.00% | 13.00% | 13.00% | 14.00% | 13.00% | 8.00% |

## To be EFFICIENT and make best use of available resources

| Indicator Name | Ref | Target | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Planned Surplus/ Deficit (YTD) £'000 | | Planned Cumulative | £710 | £1,434 | £2,104 | £2,282 | £3,069 | £3,480 | £3,763 | £4,460 | £5,431 | £5,823 | £6,529 | £7,000 |
| Actual Surplus / Deficit (YTD) £'000 | | <= Planned | £696 | £1,375 | £2,027 | £2,297 | £3,098 | £3,440 | £3,741 | £4,429 | £5,373 | £5,622 | £6,207 | £5,729 |
| Planned CIP (YTD) £'000 | | Planned Cumulative | £167 | £333 | £500 | £667 | £833 | £1,000 | £1,167 | £1,333 | £1,500 | £1,667 | £1,833 | £2,000 |
| Actual CIP (YTD) £'000 | | >= Planned | £46 | £114 | £170 | £226 | £283 | £511 | £793 | £1,075 | £1,357 | £1,357 | £1,357 | £1,500 |
| Planned Cash Balance (YTD) £'000 | | Planned Cumulative | £1,189 | £1,000 | £2,242 | £1,001 | £1,001 | £2,816 | £1,001 | £1,001 | £1,152 | £1,000 | £1,853 | £1,001 |
| Actual Cash Balance (YTD) £'000 | | >= Planned | £4,913 | £4,898 | £5,395 | £4,517 | £4,318 | £3,764 | £3,568 | £3,706 | £4,991 | £5,713 | £10,546 | £4,897 |
| Planned Capital (YTD) £'000 | | Planned Cumulative | £119 | £436 | £1,113 | £1,330 | £1,597 | £3,049 | £3,156 | £3,474 | £3,722 | £3,990 | £4,098 | £4,314 |
| Actual Capital (YTD) £'000 | | >= Planned | £89 | £220 | £311 | £602 | £914 | £1,221 | £1,380 | £1,549 | £2,271 | £2,383 | £2,981 | £5,023 |
| Monitor: Financial Sustainability Risk Rating: Capital Cover | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 4 | 4 | 4 | 4 | 4 | 4 |
| Monitor: Financial Sustainability Risk Rating: Liquidity | | 2 (1 from Sep 2016) | 2 | 2 | 1 | 1 | 1 | 1 | 4 | 4 | 4 | 3 | 4 | 4 |
| Monitor: Financial Sustainability Risk Rating: I & E Margin | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 4 | 4 | 4 | 4 | 4 | 4 |
| Monitor: Financial Sustainability Risk Rating: Variance to Plan | | 4 | 4 | 4 | 4 | 3 | 3 | 4 | 1 | 1 | 1 | 1 | 1 | 1 |
| Monitor: Financial Sustainability Risk Rating: Overall Score | | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | 3 | 1 |
| Monitor: Financial Sustainability Risk Rating: Agency Cap | | 0 | 51 | 25 | 57 | 88 | 75 | 68 | 138 | 177 | 136 | 158 | 157 | 159 |

Liverpool Women's NHS Foundation Trust

# LWH - The Board Report 2016/17

Key: TBA = To Be Agreed. TBC = To Be Confirmed, TBD = To Be Determined, ID = In Development

## To deliver SAFER services

| Indicator Name | Ref | Target | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Safer Staffing Levels (Overall - includes Registered and Care Staff) | | >= 90% | 92.78% | 91.92% | 92.60% | 91.72% | 86.86% | 89.53% | 89.14% | 93.55% | 89.35% | 93.58% | 93.07% | 95.08% |
| Serious Incidents: Number of Open SI's | | Monitoring Only | 23 | 23 | 20 | 20 | 20 | 14 | 17 | 15 | 16 | 18 | 18 | 17 |
| Serious Incidents: Number of New SI's | | Monitoring Only | 1 | 2 | 4 | 2 | 2 | 2 | 5 | 3 | 5 | 3 | 1 | 0 |
| % of women seen by a midwife within 12 weeks | | >= 90% | 96.82% | 85.53% | 95.70% | 94.88% | 91.78% | 93.28% | 92.38% | 93.91% | 93.38% | 91.88% | 94.77% | 87.00% |
| Neonatal Bloodstream Infection Rate | | TBD | 1.11 | 0.00 | 0.00 | 1.30 | 0.36 | 0.19 | 0.00 | 0.00 | 0.42 | 0.20 | 0.64 | 0.00 |

## To deliver the most EFFECTIVE outcomes

| Indicator Name | Ref | Target | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer: Referral to Treating Trust by day 42 | EXP_11 | 100% | 50% | 50% | 50% | 100% | None | 100% | 100% | 0% | 50% | 100% | 100% | 100% |
| Biochemical Pregnancy Rates | | > 30% TBC | 45.94% | 47.62% | 46.21% | 44.70% | 47.13% | 48.63% | 45.58% | 45.13% | 54.00% | 46.88% | 47.19% | 48.18% |
| Still Birth Rate (excludes late transfers) | | TBD | 0.00 | 0.01 | 0.01 | 0.01 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.01 | 0.00 |
| Neonatal Deaths (all live births within 28 days) | | Rate per 1000 TBD | 4.35 | 1.44 | 2.90 | 6.65 | 1.33 | 2.66 | 0.00 | 2.73 | 2.92 | 2.74 | 5.47 | 3.09 |
| Returns to Theatre | | <= 0.7% TBC | 0.64% | 1.03% | 0.50% | 0.51% | 0.22% | 0.21% | 0.32% | 0.56% | 0.74% | 1.18% | 0.12% | 0.21% |

## To deliver the best possible EXPERIENCE for patients and staff

| Indicator Name | Ref | Target | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Maternity: Triage within 30 minutes | KPI_35 | >= 95% | 91.50% | 89.05% | 87.86% | 90.17% | 91.66% | 87.90% | 88.24% | 90.49% | 80.48% | 83.12% | 86.16% | 85.45% |
| Number of Complaints received | | <= 15 | 15 | 5 | 13 | 18 | 13 | 19 | 16 | 10 | 8 | 11 | 9 | 7 |
| 18 Week RTT Incompletes (aggregate) | | >= 92% | 95.71% | 95.90% | 93.86% | 95.20% | 94.28% | 92.63% | 92.20% | 93.03% | 92.86% | 92.68% | 92.74% | 92.76% |
| Friends & Family Test | | > 75% | 99.26% | 98.47% | 98.60% | 97.52% | 98.37% | 99.11% | 98.51% | 97.85% | 98.78% | 98.04% | 100.00% | 92.22% |
| % Women that requested and Epidural, but weren't given one for non-clinical reasons | | <= 5% | 6.37% | 3.66% | 6.29% | 6.04% | 5.45% | 5.66% | 7.56% | 7.58% | 4.32% | 5.92% | 4.14% | 7.09% |
| % Women given one to one care whilst in established Labour (4cm dilation) | | >= 95% | 96.86% | 96.08% | 94.44% | 95.74% | 95.60% | 93.23% | 95.97% | 99.12% | 97.09% | 97.50% | 98.17% | 97.47% |
| 6 Week Wait Diagnostic Tests | | >= 99% | 98.96% | 97.47% | 97.85% | 100% | 97.00% | 100% | 99.22% | 98.26% | 98.3% | 98.6% | 98.6% | 98.8% |
| Last Minute Cancellation for non-clinical reasons (Cumulative) | | <= 4% | 0.20% | 0.58% | 0.76% | 0.66% | 0.62% | 0.63% | 0.63% | 0.70% | 0.70% | 0.79% | 0.74% | 0.73% |
| Last Minute Cancellation for non-clinical reasons (Not re-admitted within 28 days) | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Failure to ensure that sufficient appointment slots are available on Choose & Book | | < 6% | 16.29% | 13.23% | 3.13% | 22.48% | 18.47% | 7.15% | 6.95% | 3.53% | 5.22% | 2.02% | Not Available | Not Available |

Liverpool Women's NHS Foundation Trust

# Safe Staffing Report Month 12 - March 2017

| Ward | RN/RM | | | Unqualified | | | Staff Availability | | Care Delivery | | Nurse Sensitive Indicators | | | | | | | | | Patient Experience | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Fill Rate Day% | Fill Rate Night% | RN/RM CHPPD | Fill Rate Day% | Fill Rate Night% | Total Workforce CHPPD | Sickness % | Vacancy % | Numis Indicators (N) | Numis indicators achieved (N) | Red Flag Incidents Reported (N) | CDT | MRSA | Falls no harm (n) | Falls Harm (N) | HAPU grade 1&2 | HAPU Grade 3&4 | Drug Admin Errors | New Complaints | FFT (no of responses) | % Recommend this hospital |
| Gynae | 98.4% | 100.0% | 4.4 | 95.0% | 100.0% | 2.6 | 1.67% | 17% | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 80% |
| *Narrative* | The vacancy of 17% is due to the inpatient redesign and the re view of the work force. The vacancies will be transacted in April 2017. There has ben no compromise to patient safety. The Friends and Family score relates to the feedback of 10 patients. it has been identified by the interim matron that the ward mangers must work with their clinical teams to improve compliance so that we can obtain a wider over view of patients feedback. In April the interim Head of nursing, intermit matron and ward mangers will be undertaking daily audits of the comfort rounds in all clinical areas, this will include speaking directly to patients to obtain real time feedback regarding their experience. The feedback from the friends and family test will be fed back at the daily huddles so staff are aware of both positive and negative feedback from patients. | | | | | | | | | | | | | | | | | | | | |
| Gynae 2 | | | | | | | | | | | | | | | | | | | | | |
| *Merged with Ward 1* | | | | | | | | | | | | | | | | | | | | | |
| Delivery & Induction Suites | 85.4% | 91.4% | 26.8 | 111.3% | 79.6% | 4.5 | 4.49% | 8% | | | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | N/A | N/A |
| *Narrative* | Delivery suite sickness has slightly increased this month, the ward manager is working closely with HR to ensure all staff are on the appropriate stages within the Sickness and Absence policy. There has been 1 new complaint that has been completed by the ward manager and a brief description added to the weekly brief within delivery suite. | | | | | | | | | | | | | | | | | | | | |
| Mat Base | 97.7% | 100.0% | 3.9 | 78.7% | 92.5% | 2.1 | 5.79% | 6% | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 17 | 88% |
| *Narrative* | Maternity base sickness has increased from the previous month all staff are on the appropriate stages within the sickness and absence policy the manager is working closley with HR. | | | | | | | | | | | | | | | | | | | | |
| MLU & Jeffcoate | 84.4% | 88.7% | 31.4 | 93.5% | 93.5% | 5.7 | 7.17% | 2% | | | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | N/A | N/A |
| *Narrative* | MLU sickness has increased sognificantly this month due to short term sickness all staff are on the appropriate stages within the sickness and absence policy. | | | | | | | | | | | | | | | | | | | | |
| NICU | 104.4% | 105.4% | 10.4 | 74.2% | 51.6% | 0.8 | 5.97% | 8% | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 | 0 | N/A | N/A |
| *Narrative* | Recruitment under way for Band 5 staff with experience who will not require the Neonatal Induction programme - interviews booked for 5th May as well as non registered staff at Band 3 - interviews booked for 26th April . Sickness in month is higher than trust target with 65% of this being long term sickness. Bank shifts used to maintain safe service. Staff are beginning to return from maternity leave so dependency on bank shifts will reduce over the coming months. | | | | | | | | | | | | | | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| *Key Fill Rate* | | *<80%* | | *80.94.9%* | | *95-109.9%* | | *>110%* |
| *Key Sickness* | | *> 4.5%* | | | | *<= 4.5%* | | |
| *Key Vacancy* | | *> 10%* | | | | *<= 10%* | | |
| *Key F&FT* | | *< 95%* | | | | *>= 95%* | | |

| | |
|---|---|
| **Agenda item no:** | 2017/125 |

| | |
|---|---|
| **Meeting:** | Board of Directors |

| | |
|---|---|
| **Date:** | 5 May 2017 |

| | |
|---|---|
| **Title:** | Month 12 2016/17 Finance Report |

| | |
|---|---|
| **Report to be considered in public or private?** | Public |

| | |
|---|---|
| **Where else has this report been considered and when?** | n/a |

| | |
|---|---|
| **Reference/s:** | Operational Plan and Budgets 2016/17<br>Operational Plan 2017/18 – 2018/19 |

| | |
|---|---|
| **Resource impact:** | - |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **What is this report for?** | **Information** | ✓ | **Decision** | | **Escalation** | | **Assurance** | ✓ |

| | |
|---|---|
| **Which Board Assurance Framework risk/s does this report relate to?** | 5a, 5b |

| | |
|---|---|
| **Which CQC fundamental standard/s does this report relate to?** | |

| | |
|---|---|
| **What action is required at this meeting?** | To note the Month 12 financial position |

| | |
|---|---|
| **Presented by:** | Vanessa Harris - Director of Finance |

| | |
|---|---|
| **Prepared by:** | Jenny Hannon - Deputy Director of Finance |

This report covers (tick all that apply):

| **Strategic objectives:** | |
|---|---|
| To develop a well led, capable motivated and entrepreneurial workforce | |
| To be ambitious and efficient and make best use of available resources | ✓ |
| To deliver safe services | |
| To participate in high quality research in order to deliver the most effective outcomes | |
| To deliver the best possible experience for patients and staff | |

| **Other:** | | | |
|---|---|---|---|
| Monitor compliance | ✓ | Equality and diversity | |
| Operational plan | ✓ | NHS constitution | |

| **Publication of this report** (tick one)**:** | |
|---|---|
| This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting | ✓ |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedom of Information Act 2000, because such disclosure might constitute a breach of confidence | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust | |

## 1. Executive Summary

The 2016/17 budget was approved at Trust Board in April 2016. This set out a deficit of £7m for the year (as per the control total set out by NHS Improvement), an FSRR[1] of 2 and a cash shortfall of £7.7m. The planned position assumed receipt in full of £2.8m Sustainability and Transformation Funding (STF).

The Trust has delivered its 2016/17 control total, improving on the original plan by £2.3m. At Month 12 the Trust is reporting a full year deficit of £4.7m against a deficit plan of £7.0m.

This position includes £2.8m planned STF, as well as £1.7m of additional STF incentive and bonus funding.

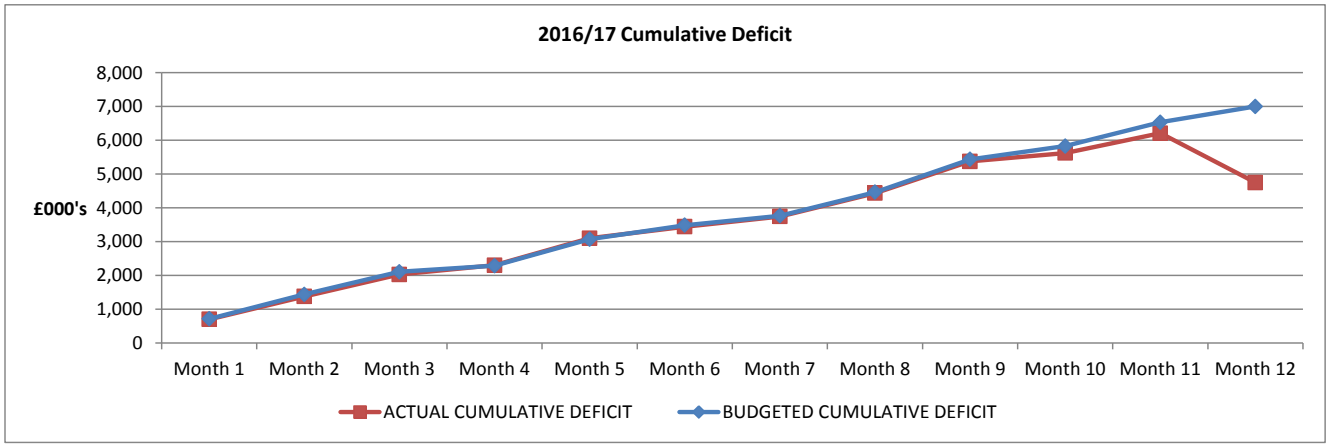
| | Month 12 Actual |
|---|---|
| **Planned Deficit (inc £2.8m planned STF)** | **£7m** |
| Non-recurrent improvement in year | (£0.6m) |
| STF incentive funding – position improvement | (£0.6m) |
| STF incentive funding – changes in discount rate | (£0.1m) |
| STF bonus funding – year end distribution | (£1.0m) |
| **Year-end deficit** | **£4.7m** |

The Trust was notified of an additional £0.983m of 'bonus' STF funding after the year end. The Trust had anticipated that some additional funding would be received based on guidance previously issued by NHSI, the amount was confirmed on 24 April 2017 and is included in the Trust's year-end financial returns to NHSI and DH.

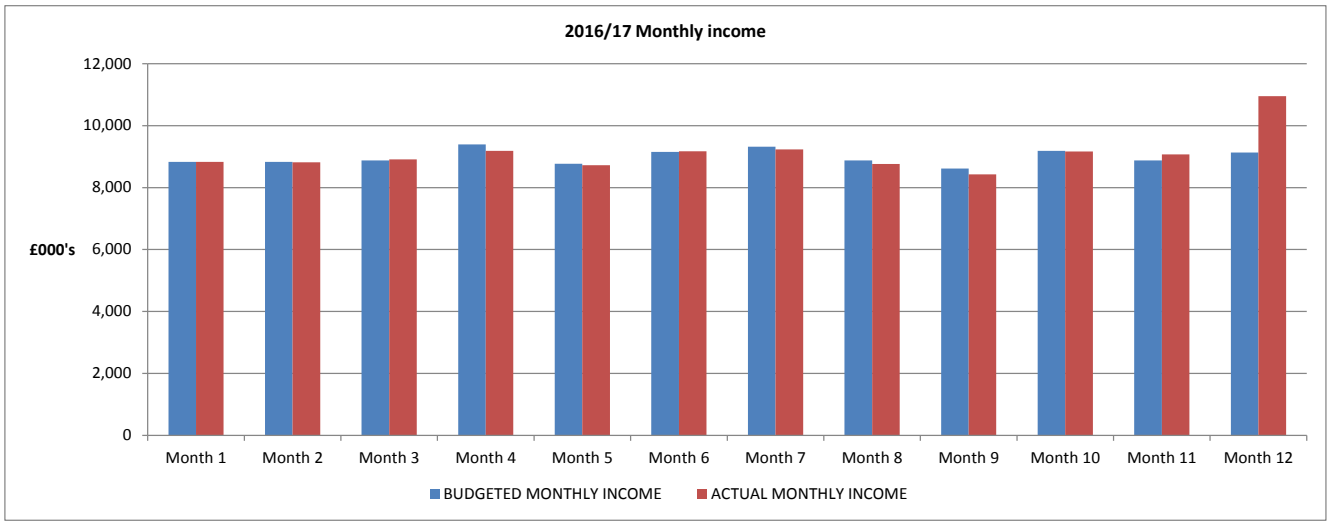
The Trust delivered a Use of Resources Rating of 3 which is equivalent to plan.

## 2. Summary 2016/17 Financial Position

The Trust has remained largely on budget overall throughout the year with non-recurrent improvements to plan identified in Quarter 3 which attracted SFT Incentive funding on a £ for £ basis. Whilst forecast during the year, this Incentive funding was recognised in Month 12 once the annual position was finalised and the income was certain.



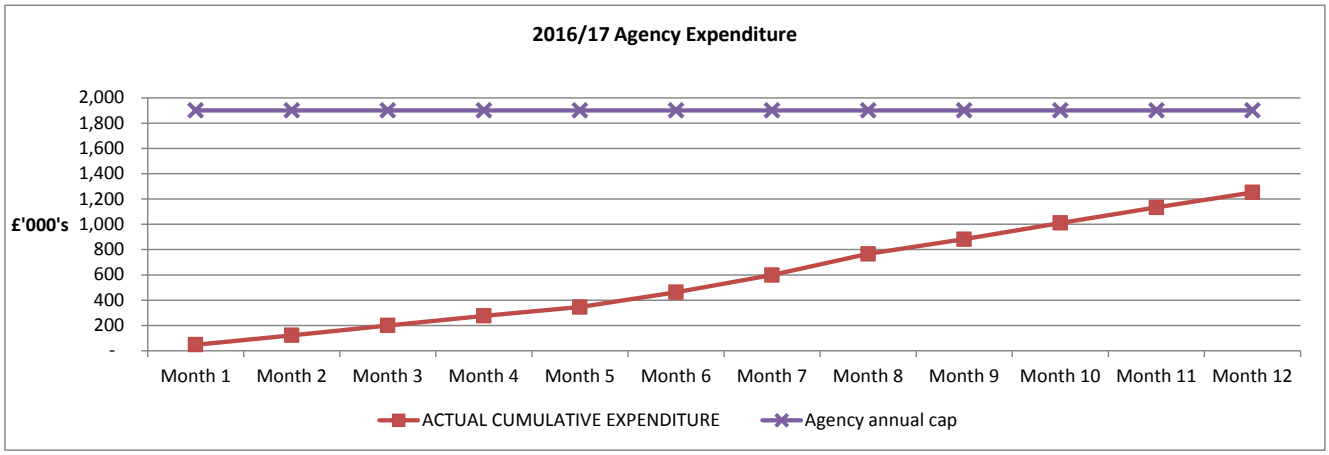

[1] Now replaced by the Use of Resources Rating under the Single Oversight Framework




Delivery of the financial position across the individual services was consistent with the latest forecasts reported to the Board. The assumptions underpinning the delivery of the 2016/17 deficit have been factored in to the 2017/18 budget setting process.

## 3. Agency Spend

Despite some challenges, the Trust remained within the agency cap set nationally and is planning to do so in 2017/18.




## 4. CIP Delivery

The Trust had an annual CIP target in 2016/17 of £2m, which represented c2% of the Trust's budgets. This was made up of ten schemes and was transacted through the ledger as part of budget setting.

Under-delivery across the CIP schemes is £1m for the full year. This arises predominantly from two schemes each valued at £0.5m, Hewitt Fertility Centre growth and theatre/inpatient redesign. These were mitigated non-recurrently at a Trust level and plans are in place to deliver these on a recurrent basis in 2017/18, with a further £0.5m from the Hewitt Centre to be delivered recurrently in 2018/19.

A full post implementation review on the 2016/17 schemes was presented to Finance, Performance and Business Development Committee in April 2017.

## 5. Cash and borrowings

During 2015/16 the Trust was in receipt of £5.6m Interim Revenue Support from the Department of Health (DH). This was in addition to £5.5m of ITFF capital funds previously drawn down in relation to the Hewitt Fertility expansion and which is now in the process of being repaid at a principle sum of £0.6m per annum.

The Trust's financial plan for 2016/17 indicated a further requirement for cash of £7.7m. During January 2017 the Trust was able to convert its working capital facility (attracting interest at 3.5%) to an uncommitted loan facility with DH at an improved rate of 1.5%. This rate was available as a result of the Trust being on target to meet the 2016/17 control total.

During the year the Trust made drawdowns totalling £7.0m against the £7.7m annual planned amount.

## 6. BAF Risk

As the Trust has achieved the 2016/17 control total it is proposed that the BAF risk in relation to the delivery of the 2016/17 financial position is superseded to reflect the risks to the 2017/18 position.

## 7. Conclusion & Recommendation

The Board are asked to note the Month 12 financial position and achievement of the control total for the financial year.

Appendix 1

# LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

# FINANCE REPORT: M12

# YEAR ENDED 31 MARCH 2017

## Contents

| USE OF RESOURCES RISK RATING | YEAR Budget | YEAR Actual |
|---|---|---|
| **CAPITAL SERVICING CAPACITY (CSC)** | | |
| (a) EBITDA + Interest Receivable | (400) | 1,469 |
| (b) PDC + Interest Payable + Loans Repaid | 2,712 | 6,038 |
| **CSC Ratio = (a) / (b)** | **(0.15)** | **0.24** |
| **NHSI CSC SCORE** | **4** | **4** |
| Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25 | | |
| **LIQUIDITY** | | |
| (a) Cash for Liquidity Purposes | (8,924) | (6,029) |
| (b) Expenditure | 108,297 | 107,794 |
| (c) Daily Expenditure | 301 | 299 |
| **Liquidity Ratio = (a) / (c)** | **(29.7)** | **(20.1)** |
| **NHSI LIQUIDITY SCORE** | **4** | **4** |
| Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14) | | |
| **I&E MARGIN** | | |
| Deficit (Adjusted for donations and asset disposals) | 6,992 | 4,739 |
| Total Income | (107,387) | (109,557) |
| **I&E Margin** | **-6.51%** | **-4.33%** |
| **NHSI I&E MARGIN SCORE** | **4** | **4** |
| Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%) | | |
| **I&E MARGIN VARIANCE FROM PLAN** | | |
| I&E Margin (Actual) | | -4.33% |
| I&E Margin (Plan) | | -6.51% |
| **I&E Variance Margin** | **0.00%** | **2.19%** |
| **NHSI I&E MARGIN VARIANCE SCORE** | **1** | **1** |
| Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)% | | |

**Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole year and year to date budget. This is because NHSI recognise the fact that an organisation would not "plan" to have a variance from plan and have not applied a calculated ratio to the budgeted columns of this metric.**

# LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
## INCOME & EXPENDITURE: M12
## YEAR ENDED 31 MARCH 2017

| INCOME & EXPENDITURE £'000 | MONTH Budget | MONTH Actual | MONTH Variance | YEAR TO DATE Budget | YEAR TO DATE Actual | YEAR TO DATE Variance |
|---|---|---|---|---|---|---|
| **Income** | | | | | | |
| Clinical Income | (8,553) | (10,455) | 1,902 | (100,881) | (102,709) | 1,828 |
| Non-Clinical Income | (584) | (504) | (80) | (7,006) | (6,537) | (469) |
| **Total Income** | **(9,136)** | **(10,958)** | **1,822** | **(107,887)** | **(109,247)** | **1,359** |
| **Expenditure** | | | | | | |
| Pay Costs | 5,614 | 5,352 | 262 | 67,352 | 66,057 | 1,295 |
| Non-Pay Costs | 2,252 | 2,222 | 31 | 26,638 | 27,344 | (706) |
| CNST | 1,192 | 1,192 | 0 | 14,307 | 14,307 | 0 |
| **Total Expenditure** | **9,059** | **8,766** | **293** | **108,297** | **107,707** | **590** |
| **EBITDA** | **(78)** | **(2,192)** | **2,115** | **410** | **(1,539)** | **1,949** |
| **Technical Items** | | | | | | |
| Depreciation | 375 | 602 | (227) | 4,500 | 4,435 | 66 |
| Interest Payable | 35 | 22 | 13 | 420 | 318 | 102 |
| Interest Receivable | (1) | (1) | 1 | (10) | (16) | 6 |
| PDC Dividend | 140 | 104 | 36 | 1,680 | 1,544 | 136 |
| Profit / Loss on Disposal | 0 | 2 | (2) | 0 | 2 | (2) |
| **Total Technical Items** | **549** | **729** | **(180)** | **6,590** | **6,283** | **307** |
| **(Surplus) / Deficit** | **472** | **(1,463)** | **1,935** | **7,000** | **4,744** | **2,256** |

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
BUDGET ANALYSIS: M12
YEAR ENDED 31 MARCH 2017

| INCOME & EXPENDITURE £'000 | MONTH Budget | MONTH Actual | MONTH Variance | YEAR Budget | YEAR Actual | YEAR Variance |
|---|---|---|---|---|---|---|
| **Maternity** | | | | | | |
| Income | (3,454) | (3,566) | 112 | (40,771) | (41,465) | 694 |
| Expenditure | 1,699 | 1,732 | (33) | 20,378 | 20,761 | (383) |
| **Total Maternity** | **(1,755)** | **(1,833)** | **79** | **(20,393)** | **(20,705)** | **312** |
| **Gynaecology** | | | | | | |
| Income | (1,986) | (1,940) | (46) | (23,965) | (24,629) | 664 |
| Expenditure | 881 | 995 | (115) | 10,554 | 11,202 | (648) |
| **Total Gynaecology** | **(1,106)** | **(945)** | **(161)** | **(13,411)** | **(13,426)** | **15** |
| **Theatres** | | | | | | |
| Income | (42) | (40) | (2) | (504) | (484) | (20) |
| Expenditure | 608 | 676 | (68) | 7,298 | 7,712 | (414) |
| **Total Theatres** | **566** | **636** | **(69)** | **6,794** | **7,228** | **(434)** |
| **Neonatal** | | | | | | |
| Income | (1,410) | (1,641) | 231 | (16,908) | (17,164) | 256 |
| Expenditure | 998 | 1,068 | (70) | 11,967 | 11,891 | 75 |
| **Total Neonatal** | **(412)** | **(573)** | **161** | **(4,941)** | **(5,272)** | **331** |
| **Hewitt Centre** | | | | | | |
| Income | (1,090) | (999) | (91) | (11,874) | (10,187) | (1,687) |
| Expenditure | 748 | 800 | (52) | 8,805 | 8,320 | 485 |
| **Total Hewitt Centre** | **(342)** | **(199)** | **(143)** | **(3,069)** | **(1,868)** | **(1,201)** |
| **Genetics** | | | | | | |
| Income | (594) | (586) | (8) | (7,143) | (6,839) | (304) |
| Expenditure | 447 | 511 | (64) | 5,358 | 5,157 | 201 |
| **Total Genetics** | **(147)** | **(76)** | **(72)** | **(1,785)** | **(1,682)** | **(103)** |
| **Clinical Support** | | | | | | |
| Income | (25) | (27) | 3 | (291) | (320) | 29 |
| Expenditure | 733 | 620 | 113 | 8,793 | 8,481 | 313 |
| **Total Clinical Support** | **709** | **593** | **116** | **8,502** | **8,161** | **341** |
| **Corporate & Trust Technical Items** | | | | | | |
| Income | (536) | (2,159) | 1,623 | (6,432) | (8,159) | 1,727 |
| Expenditure | 3,494 | 3,093 | 401 | 41,735 | 40,467 | 1,268 |
| **Total Corporate** | **2,958** | **934** | **2,024** | **35,303** | **32,308** | **2,995** |
| **(Surplus) / Deficit** | **472** | **(1,463)** | **1,935** | **7,000** | **4,744** | **2,256** |

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
BALANCE SHEET: M12
YEAR ENDED 31 MARCH 2017

| BALANCE SHEET £'000 | YEAR TO DATE Opening | M12 Actual | Movement |
|---|---|---|---|
| **Non Current Assets** | **70,539** | **72,688** | 2,149 |
| **Current Assets** | | | |
| Cash | 3,225 | 4,897 | 1,672 |
| Debtors | 4,292 | 8,201 | 3,909 |
| Inventories | 326 | 366 | 40 |
| **Total Current Assets** | **7,843** | **13,464** | 5,621 |
| **Liabilities** | | | |
| Creditors due < 1 year | 8,056 | 10,577 | 2,521 |
| Creditors due > 1 year | 1,748 | 1,717 | (31) |
| Loans | 10,794 | 17,175 | 6,381 |
| Provisions | 2,392 | 3,011 | 619 |
| **Total Liabilities** | **22,990** | **32,480** | 9,490 |
| **TOTAL ASSETS EMPLOYED** | **55,392** | **53,672** | **(1,720)** |
| **Taxpayers Equity** | | | |
| PDC | 36,610 | 37,420 | 810 |
| Revaluation Reserve | 10,019 | 12,233 | 2,214 |
| Retained Earnings | 8,763 | 4,019 | (4,744) |
| **TOTAL TAXPAYERS EQUITY** | **55,392** | **53,672** | **(1,720)** |

| | |
|---|---|
| **Agenda item no:** | 2017/126 |

| | |
|---|---|
| **Meeting:** | Trust Board Meeting |

| | |
|---|---|
| **Date:** | 5 May 2017 |

| | |
|---|---|
| **Title:** | Operational Plan 2017-19 |

| | |
|---|---|
| **Report to be considered in public or private?** | Public |

| | |
|---|---|
| **Where else has this report been considered and when?** | |

| | |
|---|---|
| **Reference/s:** | |

| | |
|---|---|
| **Resource impact:** | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **What is this report for?** | **Information** | | **Decision** | **X** | **Escalation** | | **Assurance** | |

| | |
|---|---|
| **Which Board Assurance Framework risk/s does this report relate to?** | **All** |

| | |
|---|---|
| **Which CQC fundamental standard/s does this report relate to?** | All |

| | |
|---|---|
| **What action is required at this meeting?** | Board is asked to approve:<br>1. The Trust Operational Plan 2017-19 |

| | |
|---|---|
| **Presented by:** | Chief Executive |
| **Prepared by:** | |

This report covers (tick all that apply):

| **Strategic objectives:** | |
|---|---|
| To develop a well led, capable motivated and entrepreneurial workforce | **X** |
| To be ambitious and efficient and make best use of available resources | **X** |
| To deliver safe services | **X** |
| To participate in high quality research in order to deliver the most effective outcomes | |
| To deliver the best possible experience for patients and staff | **X** |

| **Other:** | | | |
|---|---|---|---|
| Monitor compliance | | Equality and diversity | |
| Operational plan | | NHS constitution | |

| **Publication of this report** (tick one)**:** | |
|---|---|
| This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting | **x** |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication | |
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| This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust | |

Liverpool Women's NHS Foundation Trust

Included in this document is the Trust Operational Plan 2017-19 for approval.

NHS

# Operational Plan 2017-18

## *Liverpool Women's NHS Foundation Trust*

*[FINAL May 17]*

# Contents

# 1. Executive Summary

Liverpool Women's NHS Foundation Trust (LWH) is a specialist acute trust dedicated to the care of women, babies and their families. The Trust provides maternity, gynaecology and neonatal services as well as reproductive medicine and genetics. The Trust has a turnover of £104m, employs circa 1,400 staff and delivers care to circa 60,000 patients each year. The Trust had a planned deficit in 16/17 of £7m after receipt of £2.8m of sustainability and transformation funding i.e. an underlying deficit of £9.8m.

The Trust has a strong track record of operational and financial control achieving all patient access targets and delivering levels of cost improvement above the national average for several years. In the last five years the Trust has achieved cost improvements totalling £26.2m. National benchmarking shows that the Trust has consistently demonstrated that it is an efficient organisation.

However in June 2014 the Trust formally notified regulators and commissioners that it was no longer clinically or financially sustainable in the long term. The Trust has undertaken several detailed reviews since that time which all came to the same conclusion. In November 2015 the Trust published the Future Generations Strategy which detailed the clinical case for change and recommended that services be relocated to the Central University Hospital Campus (Royal Liverpool hospital site). Commissioners and regulators have accepted the clinical case for change.

Liverpool CCG have produced a further pre consultation businesses case, approved in November 2016, which also concluded that the preferred option would be to relocate services to the Central University Hospital Campus. This involved a capital cost of approximately £104m and resulting revenue savings of £4.6m.

NHS England whilst accepting the clinical case for change are not prepared to move to public consultation until the capital for the scheme can be identified and affordability concerns addressed, which includes resolving the underlying deficit of the Trust. Further work will be required to satisfy these concerns; the Trust is currently working with Commissioners and NHS England to address the concerns.

However, even if public consultation were to proceed immediately and the CCG were to conclude that the preferred option were to progress, the relocation of services would require a minimum of five years given the application process for capital which the Trust would need to follow and the site issues at the Central University Hospital Campus. The clinical case for change has now been known and accepted by the LWH Board for over two years. The clinical risks associated with the clinical case for change now need to be mitigated. Liverpool CCG, NHS England and NHS Improvement accept the do nothing option is no longer sustainable.

The pre consultation business case did identify the cost of meeting the clinical case for change if services remained on the current site and this equated to £41.6m of capital and an additional annual revenue cost of £4.2m.

The Board have carefully assessed the immediate clinical risk, taking advice from the clinicians at the Trust, and believe mitigation is now required. The Trust will therefore be investing immediately in additional consultant cover for the Trust. The Trust is also requesting capital, in the form of a business case to NHS Improvement, to address the immediate issues on the neonatal unit arising from inadequate estate.

The following sections of the operational plan outline the Trust's approach to clinical risk, quality planning, workforce issues, patient activity and the financial forecast.

.

## 2. Vision and Values

The Vision, Aims and Values have been developed over a long period of time with input from the Board, Staff, Governors and Stakeholders.

| | | |
|---|---|---|
| Our vision: | | To be the recognised leader in healthcare for women, babies and their families |
| Our strategic aims – WE SEE | W | To develop a well led, capable, motivated and entrepreneurial Workforce; |
| | E | To be ambitious and Efficient and make best use of available resources; |
| | S | To deliver Safe services; |
| | E | To participate in high quality research in order to deliver the most Effective outcomes; |
| | E | To deliver the best possible Experience for patients and staff. |
| Our values – We CARE and We LEARN: | | Caring – we show we care about people; |
| | | Ambition – we want the best for people |
| | | Respect – we value the differences and talents of people; |
| | | Engaging – we involve people in how we do things; |
| | | Learn – we learn from people past, present and future. |

## 3. Future Generations

### Review of Women's and Neonatal Services

The Trust submitted a five year plan to Monitor (now NHSI) in June 2014 which set out the financial and clinical challenges faced by the Trust. The Trust reviewed the strategic options and produced a report in November 14. However the Trust clinicians requested further time to review the clinical evidence.

Therefore throughout 2015/16, the Trust continued the development of the 'Future Generations' strategic plan which aimed to address the achievement of long term clinical and financial sustainability.

In December 2015, the resulting business case received formal approval from the Trust Board and was submitted to Monitor and Liverpool CCG for review. Liverpool CCG accepted the case for change and commissioned its own review into Women's and Neonatal services.

The review was supported by an external consultancy and a wide range of clinicians and commissioners. The overall governance was undertaken by a Project Oversight Group at which all stakeholder groups were represented. This was supported by a Clinical Reference Group, again clinicians from all stakeholder groups were represented. The review followed a standard option appraisal methodology.

Liverpool CCG concluded the Pre-consultation Business Case (PCBC) in November 2016. The PCBC presents four short listed options including;

- Enhancing the Crown Street site to meet the clinical case for change
- Minimum enhancements to the Crown Street site, which did not meet the clinical case for change
- Relocating services to Alder Hey Children's NHS FT in a new build and
- Relocating services to Royal Liverpool and Broadgreen University Hospitals NHS Trust in a new build

Of the four short listed options the PCBC contains evidence which clearly demonstrates that one option, relocation to a new build co-located with the Central University Campus, scored highest in all domains under consideration within the options appraisal framework, those being quality, feasibility, financial sustainability and strategic fit.

The indicative financial implications of the options are set out below. A move to the Central University Campus site presents the most favourable Net Present Value of the four options considered.[1]

| £000 | Royal Liverpool | Alder Hey | Crown Street Minimum | Crown Street Enhanced |
|---|---|---|---|---|
| Capital Cost | 104,280 | 101,785 | 20,350 | 41,600 |
| Net Revenue Cost/(Saving) | (-4,635) | (-2,961) | 2,651 | 4,182 |
| NPV 30 Years Cost/(Saving) | 19,033 | 47,326 | 69,107 | 118,516 |
| **NPV Ranking** | **1** | **2** | **3** | **4** |

NHS England whilst accepting the clinical case for change are not prepared to move to public consultation until the capital for the scheme can be identified and affordability concerns addressed, which includes the underlying deficit of the Trust.

The preferred solution would take at a minimum of five years to implement if agreed because the area on the site of the Central University Hospital Campus (Royal site) will not be available until the current PFI on that site is completed and the existing building demolished. In addition the Trust will need to apply for capital and produce a range of business cases demonstrating affordability.

Therefore an interim solution will need to be identified to mitigate the clinical risk associated with the clinical case for change.

## Management of clinical Risk as Identified through the clinical Case for Change (Future Generations Strategy)

Two comprehensive in-house and CCG-led service reviews in the last three years have highlighted several important, escalating clinical safety weaknesses. These are outlined service-by-service below together with planned measures to mitigate the clinical risks. These mitigations, while significant, will nevertheless fall well short of the full benefit that would be realised by relocation of the services to a hospital site already providing multidisciplinary acute adult care. This is because relocation would give rapid access to medical and surgical teams from other specialties to assist with a full range of acute and sub-acute medical or surgical complications, access to a specialised cardiac arrest team and access to a Level 3 Intensive Care Unit, none of which can be provided at Crown Street. Relocation would also obviate the need for the high-risk ambulance transfer of acutely ill women between hospital sites.

### *Neonatology*

It is incumbent upon the health service to provide the best possible quality of care to newborn babies who have medical needs. The neonatal unit at Liverpool Women's Hospital receives a high volume of babies facing the most severe medical challenges. At the Crown Street site, there are two key areas of concern. The first relates to deficiencies in the estate. The second relates to the provision of specialised staff.

The current estate at LWH is not fit for the purpose of providing neonatal intensive care. There is insufficient floor space for neonatal cots - this increases the risk of life-threatening infection. One such infective event has already led to the need for a four-cot reduction in capacity at LWH within the last 18 months and in other UK

[1] The NPV calculations do not take into account potential savings in relation to changes in organisational form.

sites, similar estate deficiencies have resulted in more extensive outbreaks of infection. In addition, there is a shortage of parental accommodation. The unit does not comply with Hospital Building Note (HBN) specifications, despite previous investments. To make the estate fit for purpose, there will need to be a significant capital outlay and this has been detailed in the financial section of this document.

The current provision of Consultant Neonatologist resident cover falls short of the 12/7 standard recommended by the British Association of Perinatal Medicine (BAPM). An investment in five additional Consultant Neonatologists is required for this purpose. The present availability of senior trainees in the specialty is low so a step-wise increase in numbers will be required at a rate of one new consultant per year in five consecutive years.

In addition, developing an Advanced Neonatal Nurse Practitioner (ANNP) team is seen as a key local strategy to counter a nationally experienced shortfall in the numbers of neonatologists in the medical workforce. Such a workforce redesign could exacerbate existing neonatal nursing shortages in Cheshire and Merseyside and would require investment in backfill of posts.

Work is progressing towards the provision of a single NICU service across two sites, Liverpool Women's and Alder Hey, with this work being overseen by the ODN.

### *Maternity*

The escalating problem facing the maternity service relates to the fact that major risk factors for serious maternal morbidity and mortality are increasing. These include population factors such as increasing levels of obesity and delay of pregnancy to a later age, plus more specific medical factors such as an increase in the numbers of women with severe medical co-morbidities who are now choosing to reproduce. These are nationally encountered phenomenae but they are particularly relevant to the Liverpool population because of its high-risk socio-economic profile. To mitigate, an increase in Consultant Obstetrician numbers is planned, to provide twenty-four hour Delivery Suite presence on seven days per week. To achieve this, eight WTE Consultant Obstetricians will be required in addition to the present quota. It is acknowledged that the present availability of senior trainees in the specialty is low so a step-wise increase in numbers will be required at a rate of one new consultant per year in eight consecutive years. Improvements to crucial support services would also be required for optimal clinical benefit, to include: provision of an on-site blood bank, provision of on-site CT and MRI facilities and provision of on-site laboratory services for blood testing. Each of these facilities would require an initial capital outlay then full personnel support, which may not presently be achievable.

### *Gynaecology*

The escalating problem facing elective and semi-elective gynaecological services relates to the fact that a rising number of women are accessing care, who have multiple medical co-morbidities and/or risk factors for severe surgical complications. As a result, the service has become increasingly reliant upon specialist input from other medical and surgical specialties to ensure that treatment is carried out in the safest way. In addition, the volume and complexity of emergency work being dealt with through the Gynaecology Emergency Department has risen steadily in recent years, while gynaecological support for the management of acute, life-threatening obstetric haemorrhage on the Delivery Suite also has to be provided. These factors are placing significant demands upon the Consultant Gynaecologists who presently, at times, have to continue performing their elective work while simultaneously covering emergencies. To mitigate, an increase in Consultant Gynaecologist numbers is planned: to fund the attendance of Gynaecological Oncologists at specialised MDTs, to fund the attendance of Consultant Gynaecologists at joint operating lists at RLUBH, to increase the number of sessions provided by Consultant Gynaecologists in the Emergency Department from two to ten per week, to increase the provision of acute surgical operating lists at the Crown Street site from

one to two per week and to provide two acute care ward rounds per day in keeping with the Seven Day national agenda. This plan will require the employment of two WTE Consultant Gynaecologists in addition to the present quota. The present availability of senior trainees in the specialty is low so a step-wise increase in numbers would be required at a rate of one new consultant per year in two consecutive years.

In addition, the purchase of clinical sessions from specialists in colorectal surgery (3.0 PA), urology (2.5 PA) and radiology (with specialised pelvic imaging expertise, 2.0 PA) is planned together with support from a dermatologist, psychologist and HDU Educator. Finally, the purchase of sentinel node biopsy equipment is planned for diagnostic use in the cancer services. This group of measures will bring the service into closer alignment with nationally accepted standards of care, although not fully closing that gap.

### *Anaesthesia*

There are no physicians or surgical specialty doctors present on the Crown Street site and no support from the Critical Care Network to provide a Level 3 Intensive Care Unit on that site. In addition, Modernising Medical Careers has brought about early specialisation in recent years, so present trainees in Obstetrics and Gynaecology are significantly less likely to have had training in acute medicine and critical care compared to their equivalents in previous years. The twenty-four hour presence of a Consultant Anaesthetist in the Trust on seven days per week is therefore planned, to allow for the safer provision of anaesthesia but also to allow for the most effective response to physiological deterioration across a range of life-threatening obstetric, gynaecological, medical and surgical conditions when these arise. To achieve this goal, the plan is to increase the present quota of Consultant Anaesthetists by 7.5 WTEs. It is acknowledged that recruitment into Consultant Anaesthetics posts is difficult, therefore, any additional staff to support an increase in out of hours cover would have to be done in conjunction with RLUBH and recruitment would have to be phased at a rate of one additional new consultant per year.

## COSTS ASSOCIATED WITH MEETING THE CLINICAL CASE FOR CHANGE

As detailed above the Trust's clinical body have assessed the clinical risks and determined mitigations required the planning period. As noted above the mitigations outlined below will not resolve the clinical risk, this will not occur until the Trust services are relocated to the Central University Hospital Campus. The costs of mitigating the clinical case for change are summarised below:

**Capital costs of addressing immediate clinical risks**

| | | 2017/18 | 2018/19 | Total cost |
|---|---|---|---|---|
| 1 | Costs of upgrading to the neonatal unit to address risk of infection and meet HBN standards | £7.0m | £8.0m | £15.0m |
| 2 | Capital cost of blood bank and diagnostics in 2, 3 and 4 below | £2.9m | £2.8m | £5.7m |
| 3 | Backlog maintenance to address eg fire safety, water hygiene and domestic hot water | £1.0m | £1.0m | £2.0m |
| | **TOTAL CAPITAL IMPACT** | **£10.9m** | **£11.8m** | **£22.7m** |

The Trust is finalising a business case for NHSI in relation to the capital requirements above.

**Revenue costs of addressing immediate clinical risks**

| | | 2017/18 | 2018/19 | Annual recurrent cost |
|---|---|---|---|---|
| 1 | Costs associated with addressing safety risks of multiple medical co-morbidities. Predominantly staff costs and including colorectal, urologist and radiologist consultant cover | £0.5m | £0.5m | £0.5m |
| 2 | On site blood bank to mitigate in instances of eg sepsis and haemorrhage | - | £1.0m | £1.0m |
| 3 | Enhanced laboratory diagnostics on site to include rapid processing of eg FBC, UE, blood clotting and cardiac enzymes | - | £0.7m | £0.7m |
| 4 | Enhanced on-site imaging capability to mitigate in instances of eg sepsis, thrombosis and haemorrhage | - | £0.5m | £0.7m |
| 5 | 24/7 consultant cover to deliver more effective interventions and reduce surgical complication rates | £0.5m | £0.7m | £2.7m |
| 6 | Additional depreciation in relation to capital upgrade requirements | - | £0.5m | £0.7m |
| 7 | Additional interest costs in relation to capital borrowings | - | £0.5m | £0.5m |
| | **TOTAL COST IMPACT** | **£1.0m** | **£4.4m** | **£6.8m** |

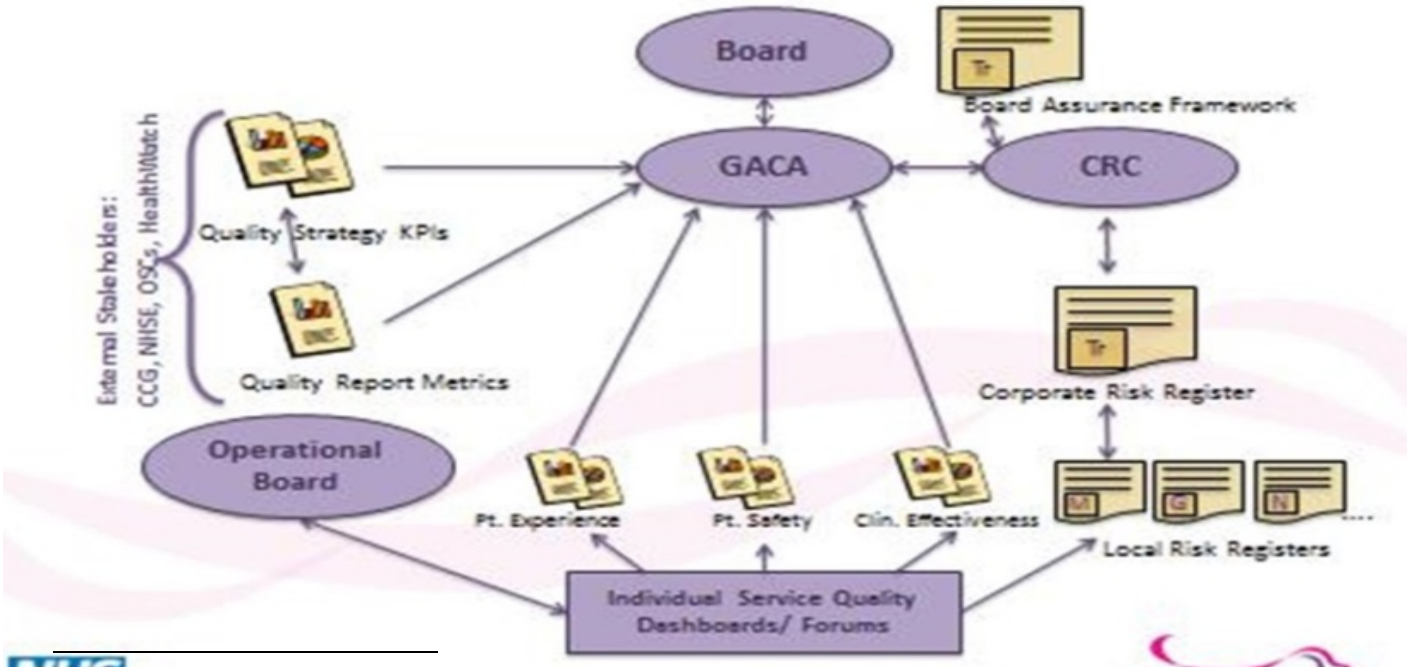
## 4. Quality Planning

### Approach to quality improvement

The Director for Nursing and Midwifery is the Trust's named executive lead for quality improvement.

Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended), are subject to an audit programme of assessment using external and internal resources. This is completed by adopting the full CQC methodology in terms of Regulations and process (KLOE), and is Trust wide to evidence 'board to ward' transparent, evidential learning used to inform Quality improvement and improve the current 'Good' CQC rating.

The Quality Improvement governance system is provided in the following schematic[2]:




[2] GACA – Governance and Clinical Assurance, CRC – Corporate Risk Committee

The Trust analyses its own performance using key quality indicators and has benchmarked these indicators against national and international comparators.

It is recognised that many different change models exist to frame the delivery of transformation and quality improvement. LWH is embracing a lean PDSA model of quality change with Prince light methodology. Service improvements are coordinated by the Trusts Transformation team and this team uses organisation-wide Master Classes to provide front line staff with a range of simple tools and techniques to deliver quality and service improvement.

## Summary of the quality improvement plan (including compliance with national quality priorities)

The Trust's quality improvement plans in relation to local and national initiatives include:

- Continued participation in all Clinical Audits that form part of the National Clinical Audit Programme as a sub section of the Healthcare Quality Improvement Programme (HQUIP).
- Care hours per patient per day have been recorded and reported appropriately and will be continued to be monitored and benchmarked to ensure the most effective utilisation of clinical teams
- Systems are already in place for the review of mortality in Gynaecology, Maternity and Neonatology. However in light of increasing concerns relating to reported Serious Incidents and mortality ,the Medical Director and Director of Nursing and Midwifery are currently reviewing those systems, comparing them with local peers and national standards to ensure that they remain in keeping with the highest standards
- The Infection Control Team implements and follows an annual work plan which is approved by the Board of Directors and is publicly available. This includes all elements of the provision of safe care with regards to infection control in addition to audits and compliance with external standards e.g. Health Care Act and NICE QS 61 & QS113. There is additional scrutiny for all areas in light of the concerns and risk identified through the Future Generations clinical case for change and specifically within Neonatal services, where the reduction in cot capacity continues due to estate limitations and risks.
- Regular audits of antimicrobial usage are conducted by Pharmacy and reported to medicines management and to the CCG (monthly). The Trust utilises an antimicrobial formulary which directs and controls antimicrobial usage. CQUIN targets for 72 hour review are being met. The Trust's antimicrobial strategy will be updated in year.
- The forward plan for End of life care LWH 2016 includes:
  - Ongoing annual review of End of Life Care for adults dying at the Trust
  - Annual relatives survey
  - Implementation and roll out of Advanced Care Planning and documentation within the Trust
  - Considering the use of Patient Reported Outcome Measures (PROMs) as part of patients ongoing assessment
  - Review of Educational Plans
  - Progressing towards the use of EPaCCs (Electronic Palliative Care Coordination system)
  - Inclusion in subsequent reports EoL care provision within Neonatal and Maternity Services.
- The Trust's improvement priorities as described in the Quality Strategy, Quality Report and CQuINs are monitored through the monthly performance report. Prior to closure intended corrective action reports are submitted and addressed through the relevant Senate (Safety, Effectiveness & Experience). Further monitoring and scrutiny is provided through reporting of associated risks to the Corporate Risk Committee.
- The Combined Quality and Performance Group, with CCG membership consider the Trust's Quality and Performance reports and the metrics included in the Quality Strategy, Quality Report and

CQuINs. Further, the Local Authority OSC's and CCGs are able to comment on and influence the metrics included in the Quality report and priorities for the upcoming periods. This ensures that the Trust's priorities are consistent with those of the STP.

## Better Births- National Maternity Review – Implementation plans for Liverpool Women's NHS Foundation Trust

- LWH in partnership with the local Maternity Vanguard one of 7 Pioneer sites for better births in the country
- Community Redesign based on better births and to provide care closer to home across boundaries.
- The pilot of the personalised maternity care budgets starting December 2016
- Bespoke enhanced midwifery service to wrap around the whole service specifically focussing on vulnerable women with perinatal mental health issues
- Working with the local vanguard towards single point of access for choice and personalisation
- Bespoke parent education services as part of the personalised maternity care budget offer – choice and personalisation
- Pilot of a homebirth team to address the continuity of carer / choice / personalisation element of choice of place of birth
- LWH in partnership with the local Maternity Vanguard one of 7 Pioneer sites for better births in the country
- Cheshire and Merseyside STP just named as one of the 7 early adopter sites of which LWH is a primary partner with the Regional Head of Midwifery/Gynaecology Lead Nurse and Clinical Director / Obstetrician
- Pilot of pop up Freestanding Maternity Units as part of the early adopter partnership work.

### Summary of quality impact assessment process

The Trust has an established Transformation and Turnaround Committee providing the governance assurance for change and transformation schemes impacting all areas across the Trust. The Committee meets formally on a fortnightly basis and reports to Finance, Performance and Business Development Committee as a subcommittee of the Board of Directors

The Turnaround and Transformation team work in a number of ways to support contributors in the development and assessment of potential schemes which may result in changes to service construct. The team has developed a pan trust communications strategy, undertaken road shows and master classes and has supported the annual planning process with director colleagues.

The Trust's current Quality Impact Assessment (QIA) process is considered to be robust and appropriate by Internal Audit and thus in keeping with the spirit reflected by the CQC. In order to ensure consistent quality of application the Turnaround Transformation team coordinate many of the QIA's required for service related schemes across the Trust. There is a robust QIA for all projects which are required to be reviewed and signed off by both the Medical Director and Director of Nursing and Midwifery.

### Summary of triangulation of quality with workforce and finance

The Trust's performance metrics are presented in a combined format including quality, workforce and financial indicators. This is reviewed on a monthly basis by the Trust Management Group with oversight by sub-Board Committees. The Turnaround and Transformation Committee has added additional scrutiny to this process with oversight across all of these strands led there by the Medical Director and Director for Nursing and Midwifery.

The reviewed indicators include inputs from NHSI, Trust Quality Strategy, Quality Schedule and CQUINs.

The Board receives regular reports across all of the corporate aims. The Trust governance meeting structure is aligned to ensure Ward to Board reporting and appropriate escalation of risks and management.

The Board uses this information both in the operational management of services and in its risk management processes. Triangulation allows themes emerging from quality, workforce and finance to be aligned and dealt with in collaboration rather than through separate processes. Further more detailed reviews are then commissioned by the Board of Directors through the sub board committees and governance structure and reported back including improvement trajectories and outcomes that provides the requisite assurance on the quality of care and enhanced productivity.

## 5. Workforce

### Fit for Future Generations

In line with the Trust's strategic direction 'Future Generations', a transformational programme has been launched, 'Fit for Future Generations'. This programme has the objective of delivering new ways of working in order to achieve financial sustainability whilst maintaining quality of patient care.

Workforce transformation and associated organisational change will therefore significantly increase in 2017/18. Organisational change in the areas outlined below is anticipated to deliver a wte reduction with a further reduction being achieved through a MARS scheme. Where possible, and only where there is no detriment to patient care, vacancies are being held and filled by bank or temporary staff, to reduce the potential for compulsory redundancy. Attrition is being closely analysed and every vacancy assessed at executive level to ensure robust controls on recruitment. Any organisational change will be quality impact assessed to ensure no adverse impact on patient care. Scrutiny and governance of organisational change is provided by the Turnaround and Transformation Committee who report ultimately into the Trust Board.

### Safe Staffing & Workforce efficiency

In recognition of the need to respond to the current and future clinical risks identified by the Future Generations Strategy, the Trust is proposing to increase its on-site Consultant presence in each of the main specialty areas. This equates to an increase in substantive Consultant numbers of 4.0 wte in 2017/18 and a further 4.0 wte in 2018/19. In order to respond to the clinical risks identified specifically in gynaecology, the Trust will be seeking additional specialist consultant and allied health support.

In response to increased levels of outpatient activity and reduced length of stay, a wholesale redesign of our inpatient processes will result in the consolidation of two gynaecology wards and utilisation of theatre space for elective work five days a week. This will mean a reduction in nursing staff and potential changes in consultant working patterns.

In order to improve our scheduling and planning processes, new technology in booking and scheduling departments will be introduced along with the creation of a single centralised reception area replacing the current individual receptions. This will provide the opportunity to rationalise administrative staff whilst providing a more responsive service to patients.

Extended nursing roles continue to mitigate the ongoing issues with junior doctor supply. The Trust is developing a new role the Gynaecology Emergency room to 'see and treat' patients to improve patient flow. Strengthening senior nursing capacity in neonatal services has seen the introduction of a Consultant Advanced Neonatal Nurse Practitioner (ANNP) in 2016/17. The numbers of ANNPs in training will be reviewed each year in line with attrition and the junior doctor pipeline.

Leadership and management development for the nursing and midwifery workforce continues to be a focus and a review of nursing & midwifery leadership will be undertaken in 2017/18. The Trust's Leadership Development Programme offers modules including resilience; business planning and service redesign. This in addition to individual and team coaching.

In response to the National Maternity Services Review, 'Better Births' an acute care collaboration has been established in Cheshire and Merseyside to develop new models of maternity care with LWH chosen as a pioneer site. As part of the redesign work a review of the Trust's community midwifery services is being undertaken to rationalise the number of geographical locations from where community midwifery services are delivered.

A review of neonatal nursing education in the first quarter of 2017/18 will deliver an increase in our nursing capacity.

## Working in partnership

Close working with Royal Liverpool and Broadgreen University Hospitals Trust and Alder Hey NHS Foundation Trust at consultant level continues with recent joint appointments in Anaesthetics and a new joint role in Paediatrics and Gynaecology. The Trust also continues to receive support in the management of the Pharmacy service from the Royal Liverpool Trust and procurement support from Aintree University Hospital.

The Trust is actively involved in streamlining and corporate service reviews across North Mersey and the wider STP footprint. In addition the Trust is seeking to implement specific Corporate Service consolidation opportunities with the Royal Liverpool and Aintree University Hospitals. Outsourcing of Switchboard, Occupational Health and Estates departments will be implemented in the first instance in the first quarter of 2017/18.

## Communication & Engagement

In light of the financial challenges and the Trust's Future Generations strategy, staff engagement and communication remains a priority. Multiple channels of two way communication are utilised including regular briefings from executive directors about the Trust's future as well as ongoing temperature checks with the local 'PULSE' survey which provides a snapshot of staff engagement between the annual national staff surveys. Following a survey of internal communication, all methods will be reviewed and refreshed in 2017/18 to ensure relevance and reach.

## Recruitment & Retention

Retention of key staff remains a priority and a challenge in the context of future organisational change. Turnover increased in 2016/17, with a particular increase in corporate areas. The current retention strategy will be reviewed and potentially revised to ensure it is meeting its objectives of achieving stability in key positions during a period of transition. Particular retention strategies for hard to recruit areas including theatres will be introduced which will include a mixture of financial and non- financial incentives.

The challenges of delivering seven day working remain as described in the 2016/17 Operational Plan. Investment in consultant staffing is required to deliver the standards, in particular the target of consultant review within 14 hours. Joint and cross- site working options will continue to be explored within the STP region.

The Trust will implement the Apprenticeship Levy with a particular focus on 'growing our own' in hard to recruit specialist areas such as Genetics, as well as investing in professional and leadership development amongst our nursing and midwifery workforce and implementing career progression structures including Nurse Associates.

## 6. Patient Numbers

### Activity 2016/17

The Trust has seen increases in activity in Maternity, Neonatal services and Gynaecology during 2016/17 primarily from our main commissioner, Liverpool CCG. This appears to be linked to an increase in population which correlates to the regeneration of the Liverpool inner city. The Office of National Statistics recently published local population figures that suggest the population will continue to increase by 1% per year for the foreseeable future based on assumptions of births and deaths.

- Maternity has seen a 3.2% increase in births over the last 12 months, this increase being made of a) increases in the local population, b) more patients from outside of the immediate catchment area choosing to receive their maternity care at Liverpool Women's Hospital and c) for clinical reasons as the recognised 'tertiary' specialised centre. As a consequence, apart from an absolute increase in birth numbers, the service has seen an increase of 10% in births with complications. This increase correlates to evidence of an upward trend in the number of patients presenting for care with underlying long term medical conditions such as obesity, diabetes or mental health / nervous disorders. Over time this trend of increasing complexity has necessitated the introduction of additional resources to maintain safely and effectiveness.
- The Neonatal service has also seen an activity increase of 4% linked to the increase in births and associated complications as described above.
- Gynaecology has seen an increase in referrals of 3%, however with advances in ambulatory practice this has only translated into an increase in first appointments and outpatient procedures. All other activity is similar to previous years.

Overall, these changes will result in a marginal overall change in the projected demand for services throughout 2017/18. Capacity planning is well established across the Trust. Service changes required are highlighted below.

### Contract 2017/18

The Trust has used 2016/17 forecast outturn to plan activity levels for 2017/18 and 2018/19. These plans are supported by local population figures and demographic data.

The contracts with main commissioners include growth of 1% for 2017/18 and a further 1% for 2018/19.

### Capacity and Demand

To ensure that the Trust can deliver activity levels and maintain access standards, capacity and demand reviews have been undertaken across all service portfolios. The Trust has used both the "GooRoo" tool and redesign support from "Four Eyes Ltd" to size future delivery models.

#### *Gynaecology*

In response to changing clinical practise the Trust has redesigned its inpatient and day case Gynaecology service. The final phase of this service redesign was taken forward in 2016/17 Q4 and will result in a reduction in inpatient beds from 39 to 24 and an increase in day case ambulatory trolleys. This redesign scheme will significantly reduce costs, circa £0.5m and is linked to the cost improvement programme.

During 2016/17 the Trust increased outpatient ambulatory services to meet growing demand. Recent changes in clinical practice and increased use of medical interventions rather than surgical operative procedures has prompted a system review of outpatient clinics. A capacity and demand review was completed during 2016/17, the outcome of which will dovetail with the introduction of new patient booking and scheduling

technology and a centralised administrative function. These changes are expected to improve patient flow, efficiency and patient experience.

The recent re-profiling of work has resulted in surplus capacity within our inpatient theatres and core bed base that is being offered to other local Trusts. Vacant capacity is already being utilised for day case ophthalmic procedures in partnership with The Royal Liverpool and Broadgreen University Hospital. It is anticipated that the Trust will seek to secure further flexible capacity support during 2017/18.

The Trust is currently recruiting additional gynaecology surgeons, theatre staff and anaesthetists to meet increased demand and to reduce the reliance on agency and enhanced payments. The Trust will continue to make joint appointments with other local Trusts where possible for theatre and anaesthetists posts as a means of maintaining skills development and to enhance both post attraction and improve retention.

### *Neonatal*

The increased demand is linked to the increase in higher risk births in Maternity and the fact that the Trust hosts the main Neonatal Level 3 ICU in Cheshire and Merseyside. Commissioners invested in additional nurses in 2016/17 that have enabled the service to maintain capacity. Gaps in the middle grade junior doctor rota's continues to be a challenge, however, the service has trained three additional Advanced Neonatal Nurse Practitioners who complete their training in March 2017 and can form part of rotas going forward.

The service continues to develop a Transitional Care offering and Neonatal Outreach Service that over time has been seen to help reduce admissions to the unit and enable earlier discharge home and improve patient experience.

Work is shortly to conclude with commissioners and the network in terms of establishing a single North West Regional Transport Service, reviewing the number of level 3 units in the region and the provision of Level 3 cots at Alder Hey for Neonatal surgery.

### *Maternity*

The service dynamically reviews inpatient capacity and its ability to flex workforce to meet seasonal demand. Unlike most other Trusts locally, seasonal variation sees an increase in activity in Maternity in the summer/autumn months rather than during the winter period. The service has a plan that allows both staffing and the environment to be flexed to meet the seasonal variation. Further work is underway to review and improve discharge pathways to ensure an efficient and safe flow of patients.

The Trust is currently mid-way through a redesigning of its Community Midwifery Services in line with recommendations from the National Maternity review: "Better Births". This will see more activity moving to strategically located community hubs and reducing attendances in the hospital, which is also in line with Liverpool CCG's Healthy Liverpool programme. This will result in reducing the number of sites used for patient care in the community whilst increasing the scale of community services offered. The Trust is working closely with the Cheshire and Merseyside Women's and Children's Partnership (Vanguard) on the recommendations in the review and also leading for the region the "Pioneer Project" and "Early Adopter" initiatives.

### *General*

Outpatient departments across all specialities have undergone a review. Further transformational work will ensure that the Trust is prepared for the "Future Generations" strategy and the Sustainable Transformational Plan.

### Key Operational Standards

The Trust has achieved all key operational standards in 2016/17 at a consolidated Trust level and is confident that these can be achieved again in 2017/18.

These are specifically for Gynaecology:

- A & E maximum waiting times 4 hours from arrival to admission/transfer/discharge 95%
- Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathways – 92%
- All Cancers – maximum 62 day wait for first treatment
  - Urgent GP referral for suspect cancer – 85%
  - NHS cancer screening service referral – 90%
- Maximum 6 week wait for diagnostic procedures - 99%

## 7. Financial Forecast and Modelling

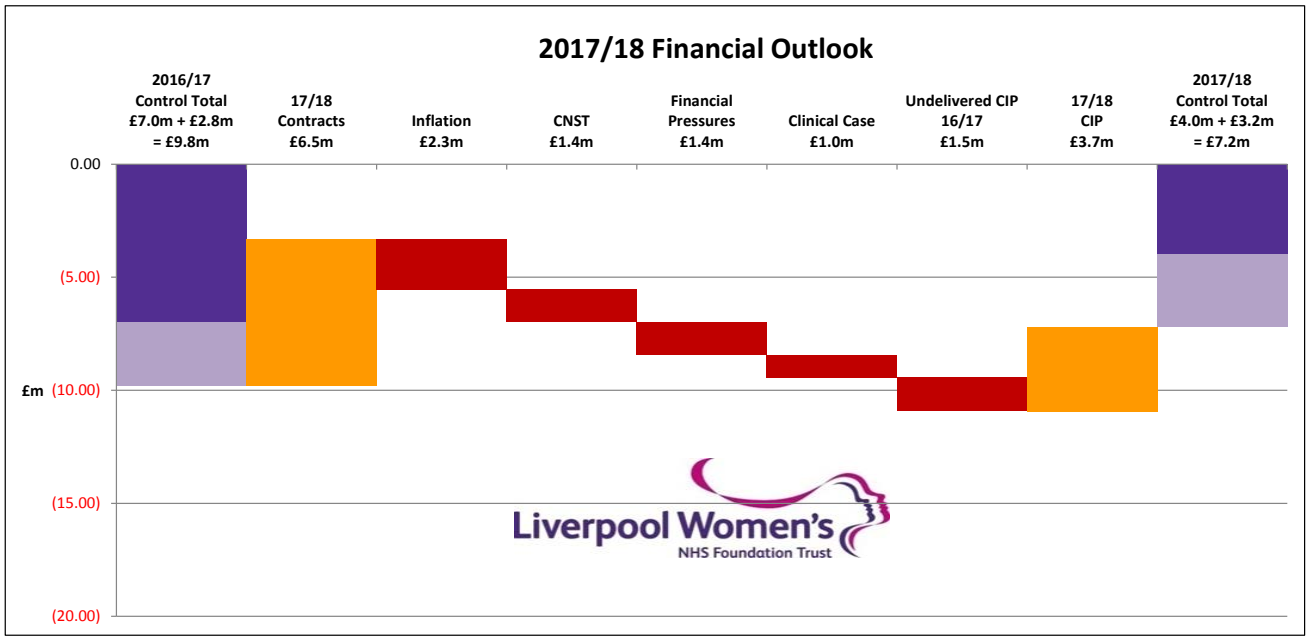
### Overview

In 2016/17 the Trust had a deficit budget of £7m in line with the control total set by NHSI. This was after £2.8m of Sustainability and Transformation Funding (STF) meaning the underlying deficit was £9.8m. The Trust ended 2016/17 within the control total and made a drawdown of £7m in cash support.

For 2017/18 the Trust has accepted a control total of £4.0m deficit after receipt of £3.2m of STF funding and has a cash support requirement of £4m before any capital expenditure in relation to the clinical case for change.

The 2018/19 control total has not yet been agreed. The Trust continues to work with NHSI to agree controls totals which allow for the costs of addressing the clinical case.

The 2017/18 financial outlook is summarised below.




Using the metrics set out in the Single Oversight Framework which came into effect on 1 October 2016, delivery of the above financial plans will give the Trust a score of 3 for 'finance and use of resources'.

## ASSUMPTIONS

Within these totals are the following assumptions which underpin the delivery of the control total.

### *Activity and Contracts*

Activity within the financial plan is predominantly based upon 2016/17 forecast outturn and results in £1.3m of additional activity above the 2016/17 planned levels. This level of activity has been agreed with commissioners and forms the basis of the workforce planning and demand and capacity planning. It also underpins the achievability of the control total.

The financial plan applies the most recent[3] HRG4+ tariff to the above activity in both of the financial plan years. In line with national guidance[4] the Trust has applied a net 0.1% inflator to local prices. This level of tariff and income forms the basis of the contract requirements which enable the Trust to meet the planned control totals and accounts for £5m of the plan.

The contract with a number of commissioners including the lead commissioner Liverpool CCG is a block contract at 2016/17 forecast outturn at HRG4+ tariff with an additional 1% in 2017/18 and 2018/19 to reflect growth in activity. This represents 85% of all CCG income received by the Trust.

The remaining CCGs will contract on the basis of activity at HRG4+ tariffs.

All contracts were signed by the 23rd December 2016.

### *Inflation*

Cost uplifts have been applied in line with national economic assumptions.

### *CNST Premium*

The CNST premium for 2017/18 has been confirmed at £15.7m which is an increase of £1.4m.

### *Cost pressures*

The Trust faces a number of unavoidable cost pressures for 2017/18 including

- implementation of an EPR, which is to be undertaken jointly with Aintree and the Royal hospital
- additional agency costs for theatre staff as a result of national staff shortages
- loss of the neonatal transport service, resulting in a reduced management fee
- additional costs to deliver the 2016/17 outturn activity which is expected to continue into 2017/18 and beyond

### *2016/17 undelivered CIP*

CIP schemes to the value of £1.5m are forecast to not deliver in 2016/17 arising from two key areas; fertility growth and inpatient redesign. These have been mitigated non- recurrently in year through tightened control over the position and are included for delivery in 2017/18 on a recurrent basis.

### *Cost Improvement Program (CIP)*

The Trust has approached CIP with energy over recent years, delivering £26.2m in the last five years through a combination of cost reductions and commercial growth. This was supported by a turnaround approach for 2014/15 and 2015/16 which identified and delivered £11m of improvement.

Schemes are subject to detailed project plans, Quality Impact Assessment and Equality Impact Assessment both before and during implementation. The schemes are signed off by the Medical Director and Director of

[3] Finalised December 2016
[4] NHS OPERATIONAL PLANNING AND CONTRACTING GUIDANCE FOR 2017-19 (September 2016)

Nursing and Midwifery before implementation. Internal audit reports have demonstrated that there are good controls over CIP identification and processes.

These processes have been further strengthened going forward with the appointment of a Turnaround and Transformation Director, the establishment of a programme management office to support identification and delivery of savings and greater oversight from a Turnaround and Transformation Committee. Clinical engagement remains critical to the delivery of the challenging efficiency programme and a robust communication and engagement strategy has been developed.

However the identification and delivery of CIP has become increasingly difficult year on year as the Trust exhausts its options to make significant improvements.

Included within the 2017/18 financial plan is a further £2.2m of CIP, in addition to the £1.5m undelivered above, which represents a total of £3.7m. This represents 3.5% of the Trust's operational cost base and is a realistic indication of what the Trust can deliver in its current form.

Further CIP is required in 2018/19 and a more transformational approach will be necessary to deliver the required targets, and it is within this year that the Trust aims to deliver savings through consolidation of corporate service functions with a view to reducing corporate overhead to 7% as per the Carter recommendations.

A summary of the targeted efficiency savings over the two years is set out in the table below.

| CIP Scheme - recurrent delivery | 2017/18 |
|---|---|
| Fertility recovery plan (2016/17 scheme) | £1.0m |
| Inpatient redesign (2016/17 scheme) | £0.5m |
| Outpatient initiatives | £0.3m |
| Workforce efficiencies | £1.0m |
| Clinical and non-clinical supplies procurement initiatives | £0.5m |
| Trust-wide estates led efficiencies | £0.4m |
| **Total** | **£3.7m** |

### *Use of agency and achievement of agency cap*

The Trust expects there to be a requirement to use agency staff in areas where there are national shortages such as theatres. The Trust is also mindful of the impact of the Future Generations strategy on staff turnover and the ability to attract new staff substantively into posts. The Trust will continue to take all steps to minimise agency spending and adhere to national guidance. As a result the Trust is planning to be within its agency financial cap for both years of this plan.

### *Capital planning*

The Trust's ongoing capital plan remains restricted in light of the deficit position and requirement for distressed finance support. Plans for 2017/18 and 2018/19 are for critical and essential items only and are subject to Quality Impact Assessments. The total operational capital spend for each year is within annual depreciation levels.

The Trust's business as usual capital requirements, excluding spend required in relation to the clinical case for change, are set out in the table below:

| Area | 2017/18 |
|---|---|
| Building requirements and estates | £1.3m |
| IM&T – Digital Strategy | £0.8m |
| Critical medical equipment | £1.7m |
| **Total** | **£3.8m** |

The items included in the plan have been identified by service leads as critical or essential. Medical equipment, which accounts for the majority of the spend, generally consists of items which are expected to require replacement during the planning years, however this is reviewed on an item by item basis at the time of replacement.

The capital requirements in relation to the Trust's longer term plans to bring the organisation back towards clinical stability are set out in section 3 above.

### *Cash flow*

The sustained deficit means that the Trust will require further cash support over the two year planning period. This is in addition to a total of £12.6m of distressed financing drawn down at the end of 2016/17.

| Requirement | Interim Revenue Support required |
|---|---|
| 2015/16 actual | £5.6m |
| 2016/17 actual | £7.0m |
| 2017/18 planned | £4.0m |
| **Total cash funding required** | **£16.6m** |

The future cash requirement will increase substantially if the Trust takes forward the mitigations for the clinical case for change noted later in the plan.

## Key Risks to the Financial Plan

- The Trust has entered block contracts with its main commissioners which include 1% for activity growth, however if growth exceeds this level the financial risk will fall to the Trust
- The remainder of the CCG contracts are of a PbR nature, if activity drops so will Trust-wide income. A number of CCGs have also indicated their intention to review procedures of limited clinical value, including gynaecology and fertility services, this may lead to a reduction in income for the Trust. Reducing the cost base accordingly within rapid timescales can be difficult.
- Delivery of CIP, particularly in 2018/19 which requires a much more transformational approach and collaboration outside of the organisation, is increasingly difficult. Whilst schemes are identified for 2017/18 there is significant risk to delivery in 2018/19.
- Availability of staffing in a difficult climate and strategic change may lead to increased agency usage.
- Given the above risks and the potential impact on the achievement of the control totals, receipt of the STF monies would represent a risk.
- The Trust would require interim support from NHS I to maintain the financial position and this has not yet been secured.

The mitigations in place to reduce the level of risk noted above are as follows;

- Robust management of activity and waiting list numbers, together with joint working with commissioners to manage the levels of demand.

- Close working with commissioners to maintain current contracts for gynaecology and fertility services demonstrating value for money to commissioners.
- Robust processes in place to manage the delivery of CIP, including engagement and communication strategy.
- Continued tight control over agency usage, as evidenced by the current limited level of agency spend, a retention package has also been established for key staff in the Trust.
- Contingency reserve of £750k to be used to offset any unexpected financial impacts.

## 8. Operational Plan within the context of the Cheshire and Mersey 5YFV

The Cheshire and Mersey 5YFV includes a number of issues which directly relate to Liverpool Women's, most importantly a review of women and neonatal services which has been led by Liverpool CCG. In addition the Trust is identified in the 5YFV as part of a merger proposal with Aintree University NHS Foundation Trust and the Royal and Broadgreen University Hospitals NHS Trust. The STP also references the work of the Women and Children's Vanguard.

### Merger with Aintree and the Royal

The Cheshire and Mersey STP also contains proposals for a three way merger between Liverpool Women's, Aintree and the Royal, which will potentially release £70m of savings. The Strategic Outline Case has been approved by all three Trusts. The Royal and Aintree are progressing towards an Outline Business Case for a two way merger by March 2018. Currently Liverpool Women's is not part of this process, at NHSI's instruction, however this remains the strategic direction for Liverpool Women's.

### Cheshire and Mersey Women's and Children's Vanguard

The Trust is actively participating in the Cheshire and Merseyside Women and Children's Services (Maternity and Paediatrics multi-specialty network). The Vanguard aims to develop a clinically managed network for Women's and Children's services (including Maternity, Gynaecology, Neonatal and Paediatric services) across Cheshire and Merseyside in order to further improve quality and ensure services are clinically and financially sustainable.

## 9. Membership and Elections

### Governor Elections

The Trust has 14 Public Governors elected by the Trust's public membership who represents the local community from: Central Liverpool; North Liverpool; South Liverpool; Sefton; Knowsley; and the rest of England and Wales. In addition there are 5 Staff Governors elected by the Trust's staff, from the following staff areas: Doctors; Nurses; Midwives; Scientists, technicians and allied health professionals; and administrative, clerical, managers, ancillary and other support staff. The Trust also has 6 appointed governors representing stakeholders.

The election process for Governors is undertaken in accordance with the Trust's constitution and follows the Model Election Rules. The Trust appoints the Electoral Reform Service as the returning officer for all Governor Elections. Over the time the Trust has been a Foundation Trust it has not had any difficulty in recruiting Governors due to the unique nature of its services and the strong brand associated with the service offering. In the last twelve months the Trust undertook an election process for 4 constituencies (2 public and 2 staff) and was able to fill the positions. In the next twelve months the Trust will undertake an election for 7 public and 2 staff governors. The Trust with the Council of Governors will actively engage with the membership and the public in order to support an active election process, see below. Governors receive induction training on appointment and meet with the Trust Secretary to identify specific needs.

Alongside the formal meetings, a range of briefing sessions and workshops take place to both inform the governors of Trust initiatives and to gain their views. The Council has recently created a task and finish Group to look at how Governors receive training and the type of training required including personal development, FT specific (such as understanding performance measures and finance) together with Trust specific (understanding the Quality Strategy, regulatory compliance, People strategy etc.).

## Membership Strategy and engagement

Led by its Patent Experience and Membership Engagement Committee, the Trust's Council of Governors developed and approved a three year membership strategy in July 2014 (2014-17) and is currently updating the strategy to look beyond 2017. The Strategy provides a 'roadmap' for the Trust's membership and public engagement over three years. Engagement with the membership and the public is at the heart of being an NHS Foundation Trust. It facilitates local accountability ensuring that those for whom the service exists – patients and the public – have an opportunity to shape, influence, comment upon and constructively challenge it as well as to positively promote it and be a part of celebrating its successes. By seeking to recruit a representative membership, listening to and involving our members, the Trust seeks to continuously improve its services with the involvement of those whose needs it aims to meet.

Throughout 2015 and 2016 governors made a significant effort to engage with as many people across the city as possible to ask what it is about Liverpool Women's that they value the most as part of our Future Generations Campaign. This involved: communicating with over 10,000 people in total at events, online and via social media; a short questionnaire was completed by the public to identify the quality of the trust's services and the aspects of our services they would most like preserved in any future developments.

Among the priorities for 2017, the Governors will seek to maintain membership numbers and recruit to under-represented groups, namely students and young adults (17-29), ethnic minorities, and residents of Sefton. The table below sets out the course of action the Governors will take for these priorities and other aims in line with the strategy.

| 2017 – 2018 | |
|---|---|
| 1. | Proactively encourage members to consider standing for election to the Council of Governors. |
| 2. | Consult and involve members in relevant engagement opportunities with respect of the Trust's Fit For Future Generations programme. |
| 3. | Maintain membership numbers and aim to recruit to under-represented groups through the use social media and appropriate governor supported public events and campaigns to support achievement of this. |
| 4. | Analyse the quality of contact information the Trust has and target regular communications, aligned to members' areas of interest. |
| 5. | Introduce multi-channel communication broadcast from Governors to members in their constituency to achieve better visibility and more productive engagement with members. |
| 6. | Introduce a dedicated and regular communication feature within the Trust's standard channels that showcases membership and Governor news, and the benefits of getting involved in order to increase recruitment. |

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| **Agenda item no:** | 2017/127 |

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| **Meeting:** | Board of Directors |

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|---|---|
| **Title:** | **Corporate Objectives 2017/18** |

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|---|---|
| **Report to be considered in public or private?** | Public |

| | |
|---|---|
| **Where else has this report been considered and when?** | N/a |

| | |
|---|---|
| **Reference/s:** | |

| | |
|---|---|
| **Resource impact:** | - |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **What is this report for?** | **Information** | | **Decision** | ✓ | **Escalation** | | **Assurance** | |

| | |
|---|---|
| **Which Board Assurance Framework risk/s does this report relate to?** | All |

| | |
|---|---|
| **Which CQC fundamental standard/s does this report relate to?** | **All/Well led** |

| | |
|---|---|
| **What action is required at this meeting?** | The Board is asked to discuss and comment on the proposed Corporate Objective 2017/18 |

| | |
|---|---|
| **Presented by:** | Chief Executive |

| | |
|---|---|
| **Prepared by:** | Director of Workforce and Marketing / Trust Secretary |

This report covers (tick all that apply):

| **Strategic objectives:** | |
|---|---|
| To develop a well led, capable motivated and entrepreneurial workforce | ✓ |
| To be ambitious and efficient and make best use of available resources | ✓ |
| To deliver safe services | ✓ |
| To participate in high quality research in order to deliver the most effective outcomes | ✓ |
| To deliver the best possible experience for patients and staff | ✓ |

| | |
|---|---|
| **Other:** | |

| | | | |
|---|---|---|---|
| Monitor compliance | ✓ | Equality and diversity | |
| Operational plan | | NHS constitution | |

| **Publication of this report** (tick one)**:** | |
|---|---|
| This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedom of Information Act 2000, because such disclosure might constitute a breach of confidence | |
| This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust | ✓ |

# STRATEGIC AIMS AND OUR CORPORATE OBJECTIVES 2017/18

The Vision, Aims and Values have been developed over a long period of time with input from the Board, Staff, Governors and Stakeholders. These were commended by both CQC and Deloitte's (when they undertook the Well Led Governance review in 2014)

Our vision:

To be the recognised leader in healthcare for women, babies and their families

Our strategic aims –
WE SEE:

**W** To develop a well led, capable, motivated and entrepreneurial **W**orkforce;

**E** To be ambitious and **E**fficient and make best use of available resources;

**S** To deliver **S**afe services;

**E** To participate in high quality research in order to deliver the most **E**ffective outcomes;

**E** To deliver the best possible **E**xperience for patients and staff.

Our values –
We CARE and we LEARN:

Caring – we show we care about people;
Ambition – we want the best for people
Respect – we value the differences and talents of people;
Engaging – we involve people in how we do things;
LEARN – we learn from people past, present and future.

| Corporate Objective<br>To develop a WELL LED, capable, motivated and entrepreneurial Workforce; | Executive Lead | Relevant Strategy |
|---|---|---|
| Improving the Health & Wellbeing of the workforce by moving to upper quartile performance for % sickness absence and stress related absence incrementally between 2015-2018 as measured by the Annual Staff Survey | MT | Putting people First Strategy |
| Improving the organisation's climate and increasing the overall staff engagement score (as measured by Annual Staff Survey & the Staff Friends & Family Test) to upper quartile for acute specialist Trusts incrementally between 2015-2018 | MT | Putting people First Strategy |
| Expanding the Trust's reach into its communities through extending its work experience, work training, guaranteed interview and apprenticeship schemes | MT | Putting people First Strategy |

| Corporate Objective<br>To be ambitious and Efficient and make best use of available resources | Executive Lead | Relevant Strategy |
|---|---|---|
| Delivering the financial plan for 2017/18, maximising the resources available to the Trust and expending these in the most effective way. | VH | Future Generations |
| Deliver the operational plan for 2017/18 | JJ | |

| Corporate Objective<br>To deliver Safe services | Executive Lead | Relevant Strategy |
|---|---|---|
| Maintain regulatory confidence & compliance | KT | |
| Delivery of in year Quality Strategy objectives | AL/DC | Quality Strategy |
| Maintain Safe Staffing levels | DC | Quality & Putting People First Strategies |
| Deliver zero C-diff rate and deliver improvements in the management and control of hospital acquired infections | DC | Quality Strategy |

| Corporate Objective<br>To participate in high quality research in order to deliver the most Effective outcomes | Executive Lead | Relevant Strategy |
|---|---|---|
| Working in partnership with providers and commissioners to ensure quality safe services are delivered to the population of the region. | JJ | Operational Plan |
| Working collaboratively with clinical services deliver the objectives contained within the Quality Account | DC/AL | Quality Strategy |
| Develop the Innovation capabilities of the Trust | AL | R&D |

| Corporate Objective<br>To deliver the best possible Experience for patients and staff | Executive Lead | Relevant Strategy |
|---|---|---|
| Providing 'best in class' patient experience within available financial pressures | DC | Patient Experience Strategy |

| Corporate Objective<br>Delivery of the Future Generations Strategy | Executive Lead | Relevant Strategy |
|---|---|---|
| Address the clinical and financial case for change by developing the preferred option of relocating women's and neonatal services to a new site adjacent to the Royal Liverpool Hospital; as supported by the Pre-Consultation Business Case produced by Liverpool CCG. | VH | Future Generations |
| Work jointly with other providers and regulators to consider future collaboration and organisational form | VH | Future Generations |
| Retain Public and Staff Confidence through an effective Communications and Engagement Strategy | MT | Future Generations |