**Meeting of the Board of Directors**
**HELD IN PUBLIC**
**Friday 3 February 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<br>10mins | | |
| 025 | Apologies for absence &<br>Declarations of interest | Receive apologies | Verbal | Chair | | - | - |
| 026 | Meeting guidance notes | To receive the meeting attendees' guidance notes | Written guidance | Chair | | R17 – Good Governance | - |
| 027 | Minutes of the previous meetings held on 6th January 2017 | Confirm as an accurate record the minutes of the previous meetings | Written | Chair | 1010<br>05mins | R17 – Good Governance | - |
| 028 | 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 | - |
| 029 | Chair's announcements | Announce items of significance not elsewhere on the agenda | Verbal | Chair | 1015<br>10mins | R17 – Good Governance | All |
| 030 | Chief Executive Report | Report key developments and announce items of significance not elsewhere | Paper | Chief Executive | 1025<br>10mins | R17 – Good Governance | All |
| BOARD ASSURANCE | | | | | | | |
| 031 | National Maternity Review update | Report key developments and actions arising from the National Maternity review | Presentation | Director of Nursing and Midwifery Deputy / Interim Head of Midwifery | 1035<br>15mins | R12 – Safe Care and Treatment | 1b&c |

| Item no.<br><br>2017/ | Title of item | Objectives/desired outcome | Process | Item presenter | Time | CQC Fundamental Standard | BAF Risk |
|---|---|---|---|---|---|---|---|
| 032 | Chair's Report from the Governance and Clinical Assurance Committee | Receive assurance and any escalated risks | Written | Committee Chair | 1050<br>20mins | R17 – Good Governance | 1 & 3 |
| 033 | Chair's Report from the Putting People First Committee | Receive assurance and any escalated risks | Written | Committee Chair | | R17 – Good Governance | 3a & 4 |
| 034 | Chair's Report from the Finance Performance and Business Development Committee | Receive assurance and any escalated risks | Written | Committee Chair | | R17 – Good Governance | 5 a - f |
| 035 | Chair's Report from the Audit Committee | Receive assurance and any escalated risks | Written | Committee Chair | | R17 – Good Governance | All |
| TRUST PERFORMANCE | | | | | | | |
| 036 | Performance Report period 8, 2016/17 | Review the latest Trust performance report and receive assurance | Written | Associate Director of Operations | 1110<br>10mins | R12&18: Safe<br>R17 – Good Governance | 3a |
| 037 | Finance Report period 8, 2016/17 | To note the current status of the Trusts financial position | Written | Director of Finance | 1120<br>10mins | R17 – Good Governance | 5 |
| TRUST STRATEGY | | | | | | | |
| 038 | Future Generations Update | To brief the Board on progress and risks | Verbal | Chief Executive | 1130<br>10mins | All | All |
| BOARD GOVERNANCE | | | | | | | |
| 039 | Board Assurance Framework & Corporate Risk Register | To review the strategic risks | written | Trust Secretary/Director of Nursing and Midwifery | 1140<br>10mins | R17 – Good Governance | All |
| BOARD GOVERNANCE | | | | | | | |
| 040 | Review of risk impacts of items discussed | Identify any new risk impacts | Verbal | Chair | 1150<br>5mins | R17 – Good Governance | All |

| Item no.<br><br>2017/ | Title of item | Objectives/desired outcome | Process | Item presenter | Time | CQC Fundamental Standard | BAF Risk |
|---|---|---|---|---|---|---|---|
| HOUSEKEEPING | | | | | | | |
| 041 | Any other business & Review of meeting | Consider any urgent items of other business | Verbal | Chair | Meeting ends 1200 | - | - |

Date, time and place of next meeting Friday 3 March 2017

## Meeting to end at 1200

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| 1200-1215<br>15mins | 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 17/27

# Board of Directors

Minutes of the meeting of the Board of Directors
held public on Friday 06 January 2017 at 1000 hrs
in the Boardroom, Liverpool Women's Hospital, Crown Street

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| PRESENT | |
| **Mr Robert Clarke** | Chair |
| **Mr Ian Haythornthwaite** | Non-Executive Director/Vice Chair |
| **Mr Tony Okotie** | Non-Executive Director/SID |
| **Mr Ian Knight** | Non-Executive Director |
| **Mr Phil Huggon** | Non-Executive Director |
| **Dr Susan Milner** | Non-Executive Director |
| **Ms Jo Moore** | Non-Executive Director |
| **Mrs Kathryn Thomson** | Chief Executive |
| **Mrs Michelle Turner** | Director of Workforce & Marketing |
| **Dr Andrew Loughney** | Medical Director |
| **Mrs Vanessa Harris** | Director of Finance |
| **Mrs Dianne Brown** | Director of Nursing & Midwifery |
| **Mr Jeff Johnston** | Director of Operations |
| IN ATTENDANCE | |
| **Mr Colin Reid** | Trust Secretary |
| For Agenda item 01 | |
| **Fiona Lemmens** | Liverpool CCG Clinical Director - Urgent and Emergency Care |
| APOLOGIES | |
| **Mr David Astley** | Non-Executive Director |

The Chair welcomed members of the public who were observing the Board meeting.

01 **Future Generations Update - Liverpool Clinical Commissioning Group Review of women's and neonatal services - Pre Consultation Business Case**

The Chair welcomed Fiona Lemmens, Liverpool Clinical Commissioning Group Clinical Director for Urgent and Emergency Care to the meeting to present the Liverpool Clinical Commissioning Group (CCG) Review of Women's and Neonatal services – Draft Pre Consultation Business Case. He advised that due to the nature of the presentation members of the public may wish to ask questions on the and he would allow this during a short period after the presentation.

Fiona Lemmens presented the update on the Review of services at Liverpool Women's and outlined the process the CCG had followed from when it started the process in March 2016, following the finalisation of the Future Generations strategy the Trust had developed since 2014, including the Trust listening events during the summer of 2015.

Fiona Lemmens advised that the review was being delivered in partnership with the South Sefton and Knowsley CCG's and advised that with the Trust, Aintree University Hospital, Alder Hey Children's Hospital and the Royal Liverpool and Broadgreen University Hospitals were fully engaged and involved in the process. She reported that the process of assessing different options had been 'clinically-led' – driven by midwives, nurses, doctors and clinicians from Liverpool Women's and other local NHS organisations, including the Aintree, the Royal and Alder Hey and following the review of options, a six week period of engagement with the public on the case for change took place as the Pre-Consultation Business Case (PCBC) was developed.

Fiona Lemmens explained that the views gathered during the engagement were used to develop the four options for the future of women's and neonatal services and these options together with a preferred option have been set out in the draft PCBC which would be published following her presentation today. Fiona Lemmens explained the four options as being: relocate women's and neonatal services to a new hospital building on the same site as the new Royal Liverpool Hospital; relocate women's and neonatal services to a new hospital building on the same site as Alder Hey Children's Hospital; make major improvements to Liverpool Women's Hospital on the current Crown Street site; and make smaller improvements to Crown Street and reported that the detailed assessment of the options had led to a 'preferred option' of a new building for women's and neonatal services on the same site as the new Royal Liverpool Hospital.

Fiona Lemmens advised that the draft PCBC presented all four options to give the public an understanding of the different issues that had been reviewed and detailed why the preferred option had been arrived at. Fiona Lemmons went on to explain that all four options required significant capital investment and that it was recognised that only the preferred option delivered the clinical case for change, the other three did not and this is articulated in the draft PCBC.

Fiona Lemmens advised that due to the requirement for capital funding NHS England and NHS Improvement had requested further work to develop detailed plans for capital funding, to show how funding could be secured, and that investment would demonstrate value for money. Fiona Lemmens reported that there was recognition that securing capital funding would be a challenge in the current environment of constrained NHS resources and that there was also a need to reflect on the findings of the broader neonatal review, which was expected to report in spring 2017.

Fiona Lemmens advised that once the work on finance and neonatal services was completed, the draft PCBC would be finalised, and submitted to NHS England, following which, if NHS England was assured about the financial component of the proposal, local authorities in Liverpool, Knowsley and Sefton would be asked to approve the decision to go out to public consultation. No final decision would be taken without first considering the views gathered during a public consultation and advised that the earliest date the public consultation could commence would be June 2016 due to the mayoral elections taking place in the spring.

The Chair thanked Fiona Lemmens for her presentation and sought comments from the Board, and referring to the process was commented that any delay had a material impact on the Trust in terms of its sustainability and consequential regulatory action. The Director of Nursing and Midwifery advised that the Trust needed at all times to look at the safety of its patients using the services and what impact the delays would have on the provision of services. She recognised and fully supported the need to move to a new site in order to deliver the clinical case for change; however with any delay there was a need to find interim clinical solutions and work arounds in order to keep patients safe. Tony Okotie agreed with the comments of the Director of Nursing and Midwifery and felt that it was important that the CCG moved towards the preferred option as quickly as possible as it was the only option that met the clinical case for change.

The Medical Director commented on the draft PCBC reporting that at all stages in the process and before the process was started with the Trust's Future Generations Strategy; clinicians, doctors, nurses and midwives had all been supportive of the need to move to a new site that would provide the best possible quality of care to patients. He felt that the work of the CCG assurance process came to the same conclusion. The Medical Director recognised that the building on Crown Street had been purpose built for the provision of women and neonatal services in the 1990s and held a special place in the heart for a lot of people; however the building would not be able to deliver the needs of women and babies in the future. He felt that the building could still be used for low risk NHS work; however it was clear that for following the review women and neonatal services could not be done on an isolated site and therefore imperative that the preferred option was only right and appropriate to future proof the services.

Ian Haythornthwaite made the comment that it was important not to lose site that any delays in the process impacted on the Trust and its financial position referring to the Chairs comment earlier and advised that delays would almost certainly result in additional financial support from the Department of Health through distressed financing which would in turn incur additional scrutiny. The Chief Executive recognised the concern and reported on the discussions she and the Director of Finance had with NHS Improvement, in seeking their support to get a strategic solution. She explained that there was recognition that if the Trust needed to remain on the Crown Street longer than previously anticipated then there would be a need for additional capital funding to support the provision of services. The Chief Executive in communicating the case for change advised that it was important that the Trust raise with the clinical leads in NHS England and NHSI the clinical case for change so that any solution found was the right one.

The Chief Executive reported on the considerable amount of briefing of staff over the last few days on the publication of the draft PCBC and the preferred option and advised that staff was fully supportive of the clinical case for change and preferred option.

The Chair referring back to the presentation asked for clarification why all four options had been included in the draft PCBC rather than just having the preferred option. Fiona Lemmens advised that this was a deliberate decision as one of the most asked questions from the public had been why can't the services remain on the crown street site and make the site safe. She explained that the draft PCBC provides details of the options considered and set out the reasons behind why the options did or did not meet the clinical case for change. Fiona Lemmons also felt that including the four options in the draft PCBC allowed for further consultation with the public in the clinical reasons for identifying the preferred option.

The Medical Director commented that in the current economic climate decisions were made on whether the finance was available. He felt it was important to note that the process undertaken over the last nine months related to what was required clinically, in the best interest of service users. He felt that although money was an important factor it needed to fit around the clinical need.

The Chair summarised the discussion and recognised the Board support for the publication of the draft PCBC and the preferred option contained within it. He thanked Fiona Lemmens for her presentation and asked that the CCG and NHS England move as quickly as it can to public consultation.

The Chair adjourned the meeting so that members of the public and media present could ask questions.

The meeting was adjourned whilst a 15 minute Q&A session took place on the publication of the draft PCBC.

The Chair opened up the second part of the meeting and welcomed members of the public, media and Governors who had stayed.

Thank You's

The Director of Operations introduced Angela Douglas, Scientific Director, Genetics Department. He explained that the Genetics service received a successful outcome from the Genetics Laboratories Accreditation Inspection for ISO 15189, by the UKAS Accreditation Inspectors, that took place on 7th and 8th September 2016. There was demonstrable evidence of the implementation of the requirements of ISO 15189 into management and technical documentation and systems, the assessment team recommended the accreditation to ISO 15189:2012 which was accepted. The Director of Operations advised that this was a fantastic achievement by the Genetics Laboratory Team.

The Director of Nursing and Midwifery introduced Sharon Owens ER Manager and advised the Board that Sharon always goes above and beyond to provide visible and dynamic leadership of the Emergency Room. The Director of Nursing and Midwifery explained that with the leadership the emergency room continued to be successful in delivering all key performance indicators and advised that with the relocation of ER there was absolutely no impact on service delivery. The Director of Nursing and Midwifery advised that Sharon in stepping in and role modelling the right leadership values and behaviours supports the delivery of clinical care to fill shifts and therefore reducing cost and need for bank.

The Board echoed the thanks on behalf of the Trust, Angela Douglas and the Genetics team and Sharon Owens for the work they do.

02 Apologies – as above.

Declaration of Interests – None

03 Meeting guidance notes

The Board noted the meeting guidance notes.

04 Minutes of previous meeting held on Friday 2 December 2016

The minutes of the meeting held on 2 December 2016 were approved, subject to minor typographical amendments.

05 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.

06 Chair's Report

The Chair provided a brief verbal report.

CQC mock inspection: The Chair reported that in June this year the Trust would be undertaking CQC style mock inspections in December 2016. He advised that the mock inspection went ahead and thanked everyone who took part. The Chair reported that it was a great turn out, with Directors, governors, clinical staff and non-clinical staff all working so closely together. The findings of the inspection were being assessed and an action plan was being developed which would be reviewed by the Board Governance and Clinical Assurance Committee (GACA). The Board would receive progress through the GACA Chairs Report. The Chair noted that the Trust intends to run these exercises twice a year which would benefit both staff and patients.

Long Service Awards: The Chair advised that he had attended the event on 12 December at which 20

staff from across a wide range of disciplines received their award from him. He understood that a total of over 610 years' service was being awarded.

Council of Governors Meeting: The Chair reported that he had received a resignation from one public Governor from the 'rest of England and wales' constituency.

The Board noted the Chair's update report.

07 Chief Executive's report

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

Ian Haythornthwaite referring to the date of 2017 in "Outpatients – Patient flow and self-check in system", asked when in 2017 new system will be installed and in operation. The Director of Operations advised that the current anticipated date was April 2017.

The Board noted the Chief Executive Report.

08 Report from the Charitable Funds Committee

Tony Okotie introduced the paper and reported that at the last Board meeting he had advised that the Annual Report and Accounts of the Charity would be presented to the Board for approval as Corporate Trustee. He advised that the paper also included an update on the focus of the Charity over the last 6 months and asked the Director of Workforce and Marketing if she would highlight any of the key activities. The Director of Workforce and Marketing referred to the report and explained the process that had taken place in merging the two main hospital charities, the Newborn Appeal and the Kitty Appeal. She explained that work was underway to develop a single strategy for the one charity under the banner "Liverpool Women's Charity". With regards to income from donations and fundraising the Charity had seen an increase by 75% in the first six months of the year compared to the same period last year, with a significant increase in on-line giving. The Director of Workforce and Marketing advised that one of the key promotional areas being addressed was the overhaul of the Trust website which would allow promotion of the Charity on its own webpage.

The Chair thanked the Director of Workforce and Marketing for the update which was noted.

Referring to the Annual Report and Accounts the Chair welcomed Victoria Brennand, the Trust's Charities Financial Accountant to the meeting to respond to questions on the accounts. He advised the Board that the Annual report and Accounts had been reviewed by the Charitable Funds Committee that comprised of both Non executive, Executive directors and senior managers at the Trust. It was the Charitable Funds Committee's recommendation that they are accepted by the Board so that they can be submitted to the Charitable Commissioners by 31 January 2017.

The Board discussed the Annual Report and Accounts and made a number of observations in terms of content of the Annual Report, the investment profile and benchmarking. Following discussion the Chair asked that the Board approve the Annual report and Account and letters of representation and authorise him to sign both documents on behalf of the Corporate Trustee.

*The Board, having received the recommendation from the Charitable Funds Committee, approved the Annual Report and Accounts for the year ended 31st March 2016 and letter of representation contained within the Report.*

09 Serious Incidents Report

The Director of Nursing and Midwifery presented the Serious Incidents Report and explained the Report's purpose was to provide the Board with an understanding of its responsibilities regarding Serious Incidents, the current key themes within Serious Incidents and show evidence of how serious

incident investigations makes a difference leading to improvement. The report was taken as read and the Chair asked for comments.

Ian Haythornthwaite referring to the theme "failure to act on test results" asked what was being done to ascertain why this was happening. The Director of Nursing and Midwifery advised on the outcomes of the investigations and reported that GACA would be discussing the all the "themes" reported in the paper and would look at whether there should be a deep dive investigation undertaken. Regarding the theme "poor outcomes following MAU Attendance", the Director of Nursing and Midwifery advised that the busyness of MAU had created a situation which had resulted in errors.

Tony Okotie referred to the increased number of SIs reported in 2016/17 against the previous year's and asked why there was such a magnitude of increase. In response the Director of Nursing and Midwifery advised that the increase was due to better reporting of SIs by clinicians and welcomed this approach. The Chief Executive supported the comments of the Director of Nursing and Midwifery and advised that it showed a healthy culture, with tolerance levels of clinicians heightened, explaining that incidents were reported first and then de-escalated if it was found not to be an incident providing full capture. The Medical Director explained that there was a clear process of capturing incidents which allowed for themes to be identified and ultimately allowing for improvements to be made from the learning's from the incidents. He felt that with improved processes, reporting would increase as would the number of de-escalations. The Medical Director also felt that some of the SIs reported had arisen due care that could not be provided because the Trust was on a standalone site.

Phil Huggon felt that the Report provided clear insight into the incidents and supported the need for the Board to see it on a quarterly basis. He felt that the Board needed to be assured that the process of reporting and the learning from each SI has embedded in the Trust. Referring to only three themes identified, Phil Huggon asked whether this was correct. Susan Milner noting the small number of SIs recognised that it would be difficult to define trends as it would with larger numbers.

Ian Knight referred to the earlier discussion on the number of de-escalated incidents, asked that future reports include the number of de-escalated incidents; he further asked that the Report include a section on learning from incidents.

The Board discussed what assurances were required recognising that SIs were reported through the Governance Structure up to GACA and into Board. It was felt that one of the main assurances the Board wanted to see was the effectiveness of lessons learned from incidents resulting in improvements in care to patients.

The Board agreed to receive SI quarterly reports and noted that the key themes identified in the Report were being appropriately managed. The Board further noted the process of reporting had improved however required additional assurance of the effectiveness of lessons learned.

The Chair asked that the Director of Nursing and Midwifery include in future quarterly SI reports to the Board the matters identified in the discussion.

*Action 2017/009: the Director of Nursing and Midwifery include in future quarterly SI reports to the Board the matters identified and provide a Serious Incidents Quarterly Report the next to be presented on 7 April 2017.*

010 Quality, Operational Performance report Period 8 2016/17

The Director of Operations presented the Performance Dashboard and reported that of the 33 indicators reported, 8 had been RAG rated red. The Director of Operations explained sickness absenteeism had seen an increase in rates over the Christmas period and reported that the majority

of sickness over that period related to short term such as gastrointestinal problems. Staffing levels had been impacted; however assurance was given that all areas remained within the appropriate staffing levels.

Referring to "Epidural not given for non-clinical reasons", the Director of Operations advised that this continued to be an outlier and he did not expect the Trust would be able to deliver against the planned target. He advised that this metric had been discussed at length in previous meeting and explained that it was a locally identified metric set by the Trust. He expected that when all the metrics were reviewed for future reporting this metric may not be in the final set for Board approval in March.

The Director of Operations presented  reported on the emerging concerns that was reported firstly in November 2016 advised that 18 Week RTT for Genetics was at 81% and due to both capacity and demand would struggle to achieve the 92% target rate in the coming months. He explained that the aggregate level was reported to NHS Improvement and for the past four months the aggregate rate had been between 92.2% and 92.9%. The Director of Operations reported that there was a risk that if Genetics performance deteriorates and/or that other areas such as Gynaecology begin to experience problems with capacity, the Trust could fail to attain the 92% in the coming months.

The Chair thanked the Director of Operations for his presentation noting the risk of non-delivery of 18 weeks RTT which he asked that the Executive continue to keep under constant review. Referring to the content of the new report he asked that additional narrative is included on actions were in place to address where the Trust was not delivering against targets.

The Chair referring to maternity triage, asked why an improvement had been made given previous reports had shown poor performance. The Director of Operations advised that improvements in workflows being introduced and also the introduction of a new manager had allowed for improvements to be made. He further advised that additional consultant presence on MAU with dedicated time had also increased improved performance in the metric. The Director of Operations advised that the metric did have a propensity to peaks and troughs and could not give an indication on when the target would be delivered, noting that this metric was set by the Trust.

The Board reviewed the Quality and Operational Performance Report and recognised the work being done to address emerging concerns and non-compliant indicators.

*Action 2017/010: the Director of Operations to bring to the Board at its March meeting a template performance report for future reporting of agreed metrics, both prescribed metrics and those required locally by the Trust.*

011 Financial Report & Dashboard Period 8 2016/17

The Director of Finance presented the Finance Report and financial dashboard for month 8, 2016/17 and reported that Trust was reporting a monthly deficit of £0.69m against a deficit plan of £0.696m which was a negative variance of £0.006m for the month. Cumulatively the Trust was slightly ahead of plan by £0.027m. She advised that following a detailed review in month 8 the Trust was on target to deliver its annual control total of £7m deficit assuming receipt of the full £2.8m Sustainability and Transformation Funding (STF). The Director of Finance advised that without the STF the true nature of the deficit was £9.8m.

The Board discussed the status of the financial position of the rust and the requirements to deliver CIP both this and the next finance year. Ian Haythornthwaite referring to the external view of the Trust, felt that there was continued support from the regulator surrounding the management of the Trust's financial position. He felt that the Executive had done exceptionally well to control the financial integrity of the Trust, whilst recognising that the Trust continued to have pressures going

forward.

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

## Review of risk impacts of items discussed

The Board noted the risks had been discussed during the meeting and the main issue was the related to the delivery of the SI report and the potential non-delivery of 18 weeks RTT.

## 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

3 February 2016

TRUST BOARD
Action Plan

| Meeting date | Minute Reference | Action | Responsibility | Target Dates | Status |
|---|---|---|---|---|---|
| 6 Jan 2017 | 2017/010 | The Director of Operations to bring to the Board at its March meeting a template performance report for future reporting of agreed metrics, both prescribed metrics and those required locally by the Trust. | Director of Operations | 3 March 2017 | Action ongoing |
| 6 Jan 2017 | 17/009 | The Director of Nursing and Midwifery include in future quarterly SI reports to the Board the matters identified in the discussion. | Director of Nursing and Midwifery | Next report 7 April 2017 | Action ongoing |
| 4 Nov 2016 | 16/278 | 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 | February 2017 | See agenda item 2017/031.<br><br>An update presentation will be provided to the Board on 3 February 2017 with a formal paper presented to the Board at the 3 March 2017 meeting<br><br>Action ongoing. |
| 7 Oct 2016 | 16/255 | 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 | ~~February 2017~~ April 2017 | 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.<br>Action ongoing. |

Chairs report

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| **Agenda item no:** | 17/030 |

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

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| **Date:** | 3 February 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:** | |
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| 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:** | | | |
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| Monitor compliance | ✓ | Equality and diversity | |
| Operational plan | | NHS constitution | |

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

**CQC Mock Inspections:** Dates for the diary- the next CQC Mock Inspections are provisionally set for Monday 8th, Tuesday 9th and Wednesday 10th of May. There'll be a morning and afternoon session each day. Results will be fed back through Effectiveness Senate and GACA .

**Flu Campaign**: There was a 76% take up rate for clinical staff.

**Olympic Brainz Monitor:** Thanks to the Alice Hiley Memorial Trust Liverpool Women's is the only hospital in Merseyside and Cheshire to have an Olympic Brainz Monitor. The Alice Hiley Memorial Trust donated the ground breaking piece of equipment to Liverpool Women's Neonatal Unit. The Monitor which costs £16k will benefit many newborn babies at Liverpool Women's Hospital. The Alice Hiley Memorial Trust was established in memory of baby Alice who was born at Liverpool Women's in July 2010. Alice lived for only six hours after she was born with a rare congenital disorder. Ever since, Alice's parents Heather & Andrew, and grandparents Anne & Roger, have worked tirelessly to ensure her memory lives on by raising money and setting up the Alice Hiley Memorial Trust. The Alice Hiley Memorial Trust raises money to fund equipment to help other babies born with life-threatening conditions, it also supports the families of babies requiring special medical care in the North West. In 2011 they purchased a Giraffe Incubator at a cost of £14,600 for the Neonatal Unit and to date they have raised a spectacular £32k+, benefiting many babies across the North West.

**National Awards:** Congratulations to Angela Douglas for being shortlisted for the Innovation Champion Award at the 2017 North West Coast Research and Innovation Awards. The winners will be announced at a prestigious event hosted by medical journalist and broadcaster, Lawrence McGinty on 9 February.

**Dedicated to Excellence:** The 2017 Dedicated to Excellence Awards will take place on Thursday, 13th April 2017, at the Marriott Hotel, Liverpool. We have 8 categories this year:

- Dedicated to Innovation and Improvement (clinical)
- Dedicated to Innovation and Improvement (non-clinical)
- Dedicated to Working together (team working and partnerships
- Dedicated to Research
- Dedicated to Patients and their Families
- Dedicated to Patient Safety
- Mentor of the Year
- Learner of the Year

There will also be:

- Employee of the Year
- Team of the Year

- Volunteer of the Year
- Foundation Award

SECTION B - LOCAL

5 Boroughs Partnership to deliver children's health services in Sefton

Following a successful tender process, from 1 April 2017, 5 Boroughs Partnership NHS Foundation Trust will be the new provider of the 0 to 19 Healthy Child Programme in Sefton.

Building on the current work to improve the health and wellbeing of children and families in the borough, the programme will include the provision of health visiting, a new enhanced service to support vulnerable families, and school nursing across Sefton.

SECTION C – NATIONAL

NHS Confederation: NHS Confederation has appointed Niall Dickson as its new chief executive. The appointment will add enormous value to the Confederation, and the health and care sector, at a crucial time for the NHS and its partners. Niall Dickson, most recently the chief executive of the General Medical Council, will help ensure the NHS Confederation remains the first port-of-call when the health service needs a voice, binding in the highest levels of experience and influence across the full spectrum of health and care services. Before his time at the GMC, he was the chief executive of The King's Fund and was for many years the BBC's social affairs editor. Niall Dickson brings with him a diverse range of skills and experience including superb leadership, a strong record of innovation and delivery, and a raft of invaluable contacts and carefully nurtured relationships in key areas. He will take up his role with us on 1 February.

17/031

National Maternity Review - Update

Presentation

Liverpool Women's NHS Foundation Trust

**Board of Directors**

**Committee Chair's report of Governance and Clinical Assurance Committee meeting held 13 January 2017**

**1. Was the quorate met?** Yes

**2. Agenda items covered**

- Medicines Management Update & Assurance
- Serious Incident Update Report
- Stillbirth Strategy
- Review of Compliance with CQC Fundamental Standards
- Emergency Preparedness, Resilience and Response (EPRR) Assurance Update
- Annual Legal Services Report 2015/16
- IT Update to Francis Report actions
- Safety, Effectiveness & Experience (SEE) Report, including performance metrics
- Statement of Purpose Annual Review
- Board Assurance Framework

**3. Board Assurance Framework (BAF) risks reviewed**

**New Risks**

Since the last Committee meeting there have been no new risks added to the BAF.

**Closed / De-escalated Risks**

The Board agreed at its meeting in December with GACA's recommendation that BAF Risk 1m (Ulysses Number 1944) be de-escalated to the Neonatal Transport Service Risk Register.

**Changes to Risk Ratings**

Since the last meeting no BAF risks have had their risk ratings changed.

**4. Issues to highlight to Board**

GACA noted the findings of the mock CQC inspection that 'key outcomes are not sufficiently visible or discussed in sufficient depth'. GACA committed to overseeing the work led by the Medical Director in reviewing how morbidity and mortality is overseen relevant learning shared within the Trust. GACA saw this as a priority that needs to be progressed with the appropriate focus, speed and diligence.

NHS

GACA were not fully assured by the medicines management update. They asked the Director of Operations to write to the Chief Pharmacist requesting a further update to be provided at the March committee meeting.

## 5. Action required by Board

None

**Author:** Dianne Brown; Director of Nursing & Midwifery

**Date:** 27 January 2017

Liverpool Women's NHS Foundation Trust

**Board of Directors**

**Committee Chair's report of Putting People First Committee meeting held 27 January 2017**

1. **Quorate?** No due to no staff side representation (ie MSC Chair or Staff Side Chair)

2. **Agenda items covered**

- Review of HR BAF Risks & Risk Appetite
- Staff Experience Story – Gynaecology : changing roles within the Trust
- Gynaecology Workforce Review Paper
- HR Directors Report *(includes FPPT, initial staff survey update, Workforce implications from the Apprenticeship Reforms and ESR data quality)*
- Review and approval of Talent Management and Succession plans to support the strategic direction of the Trust
- Workforce KPI Report [including Information governance update]
- Fit for Future Generations Update
- Payroll and Pre-employment Checks Audit
- Policy Approval
- Sub Committee Chair Reports – Partnership Forum, Joint Local Negotiating Committee, Nursing & Midwifery Board, Diversity & Inclusion Committee, Education Governance.

3. **Board Assurance Framework (BAF) risks reviewed**

- Risk associated with junior doctor's industrial action reviewed, reduced and reworded to reflect more generic risk associated with potential for industrial action

4. **Issues to highlight to Board**

- Committee approved the Talent Management Plan linked to the Trust's appraisal process & supported the proposal to mandate attendance at the Trust's Leadership Programme as appropriate to role
- Gynaecology Workforce review identified issues relating to succession planning for specialist nurse roles. Committee requested further assurance on actions to address.
- Turnover trend in gynaecology – Committee requested deep dive into turnover in gynaecology, including analysis of entry & exit data

NHS

- Policy approval – new process agreed with staff side to ensure policies could be agreed and signed off before expiry
- Payroll Audit – Reasonable Assurance. All actions, bar one, implemented and plan to finalise outstanding action in place
- Sickness – assurance gained that robust process was being followed in the management of sickness absence and that appropriate support was offered to managers and staff in the form of stress awareness, stress management and resilience training
- Fit for Future Generations – committee received details of workforce related cost improvement schemes and agreed that this should now be a regular update to the Board of Directors

## 5. BAF recommendations

- Agreed the reduction of BAF Risk 4c 'Junior Doctors Industrial Action' to a score of 4 (1x4) and the rewording of the risk to a more generic risk associated with the potential for industrial action

## 6. Action required by Board

- To approve the alteration to BAF Risk 4c as outlined above

Tony Okotie
Chair, Putting People First Committee
Date: 27 January 2016

17/034

# Board of Directors

## Committee Chair's report of Finance Performance and Business Development Committee meeting held 30 January 2017

### 1. Meeting Quorate: Yes

### 2. Agenda items covered

~ Month 9 Finance Report: The Committee was assured that the Trust was still on target to deliver the control total at year end assuming that the Trust is in full receipt of £2.8m Sustainability and Transformation Funding.

~ Performance dashboard, Month 9: the Committee noted that the Trust continued to deliver against the NHSI performance targets. The Committee received an update on delivery against CQINS and noted that there was potential financial implications that would need addressing by the end of the year

~ Cost Improvement Programme Review 2016/17: The Committee noted that as at month 9 the schemes were below plan by £0.76m, with a year-end forecast of £0.99m below plan for 2016/17 schemes and an additional £0.5m below plan carried forward from prior year schemes. Undelivered schemes had been mitigated non-recurrently in year through tightened control over the position and have been included for delivery in 2017/18 on a recurrent basis. There is Executive focus on the CIP programme to ensure grip and control was maintained and all schemes delivered in line with plan.

~ IM&T Review and EPR Update: The Committee was assured that the status of the IM&T and EPR implementation plans were progressing in line with plan and a that all risks had been addressed. The Committee noted that good clinical engagement in the EPR implementation was vital to its success.

### 3. Board Assurance Framework (BAF) risks reviewed

~ The Committee noted the BAF risks and agreed

De-escalation of Risk

- that risk 5c – 'To take forward plans to develop services nationally and internationally - Non-delivery of the expected return from expansion investment' is discontinued on the BAF as plans to develop services nationally and internationally were no longer being progressed at this time. Therefore any risks and uncertainties that would have existed were no longer relevant.

Changes to Risk Ratings

- That the risk score 5aii 'The Trust does not deliver the 2016/17 financial plan and control total' is reduced from risk score 20 (probable and catastrophic) to 15 (possible and catastrophic) in view of the improvement in the forecast position for 2016/17.

New Risks

- The Committee felt that risk 1k and 1n on the register relating to "Isolated Site of LWH - Risk: Location, size, layout and current services do not provide for sustainable integrated care package for quality service provision" and "Suitability of Neonatal Estate - Risk: Inability to safely meet the needs and demands of a changing neonatal service within the confines of the current environment and staffing establishment" should be owned and reviewed by GACA.

### 4. Issues to highlight to Board

~ Amended Terms of Reference. See Board agenda item

## 5. BAF recommendations

~ The Board to note the change of risk score under 3 above, now contained in the Board assurance Framework at Board agenda item

## 6. Action required by Board

~ N/A

17/035

# Board of Directors

## Committee Chair's report of Audit Committee meeting held 30 January 2017

### 1. Meeting Quorate: Yes

### 2. Agenda items covered

~ Follow up of Internal and External Auditors Recommendations: The Committee received an update of the outstanding internal audit and LCFS recommendations as well as actions arising from the external audit. One recommendation outstanding from the 2014/15 LCFS program which has been partially implemented, relates to Consultant Job Plans. The Committee received assurance from the Medical Director that actions had been taken to implement the recommendations.

~ Internal Audit Progress Report: Good progress had been made against the Internal Audit plan. The Committee noted that any audits that are deferred by the responsible executive would be reviewed by the Executive and a decision made on the appropriateness or not of a deferral.

~ External Audit: The Committee received the 2016/17 external audit plan which was noted.

~ Waivers of Standing Orders. The Committee noted a slight increase in waivers during the quarter against the previous quarter however recognised that the controls that put in place some time ago continue to have a positive influence with regards to the proactive management of waivers which is evidenced by the stability in the number of waivers raised compared to previous years. The Committee noted that there was a work plan underway to introduce additional price agreements, access more frameworks and competitively tender spend to further avoid the need to raise waivers.

~ The Committee received proposed changes to the Corporate Governance Manual and noted that following review of the financial delegations the current authorisation levels did not require amendment; however amendments had been made to the number (reduction) of nominated signatories on the list of authorised managers.

### 3. Board Assurance Framework (BAF) risks reviewed

~ None

### 4. Issues to highlight to Board

~ None.

### 5. BAF recommendations

~ None

### 6. Action required by Board

~ None

| | |
|---|---|
| **Agenda Item No:** | 2017/036 |
| **Meeting:** | Trust Board |
| **Date:** | January 2017 |
| **Title:** | Performance Dashboard - Month 9 - December 2016 |
| **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**

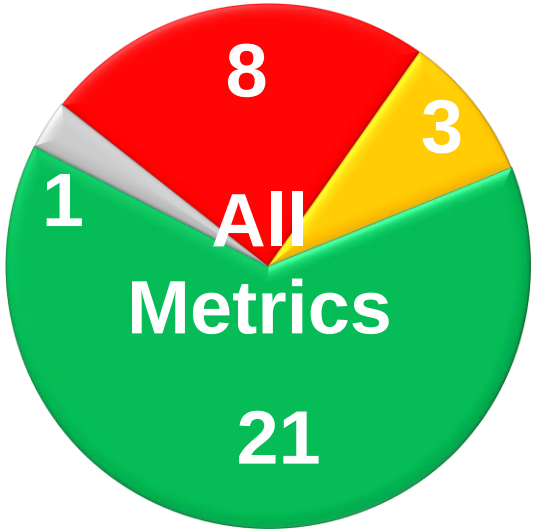
**2. Issues for consideration**

**3. Conclusion**

**4. Recommendation/s**

Liverpool Women's NHS Foundation Trust

# Performance Report - Trust Board — Month 9 - December 2016








# Performance Summary - Trust Board - Month 9 - December 2016

## Overview

Of the **33** KPI's RAG rated in the Trust Board Dashboard for December 2016, **22** are rated Green, **8** are rated Red and **3** are rated as Amber. The figure for Choose and Book is not yet available nationally, however, figures recently released for August 2016 shows a high rate of slots not available.

The KPI's rated as Red for December 2016 are:

- 2 x Finance KPI's reported separately via the Finance Report
- HR: Sickness & Absence Rate at 5.27% against a a target of <= 4.5%
- Nursing Staff Fill Rate at 89% against a target of >= 90%
- Cancer: Referral to Treating Trust by day 42 at 50% against a target of >=85%
- 6 Week Wait for Diagnostic Tests at 98.3% against a target of >= 99%
- Maternity Triage within 30 Minutes at 82.2% against a target of >= 95%

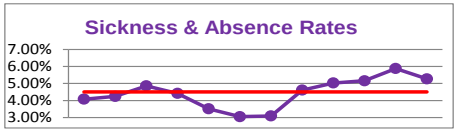
The KPIs rated as Amber for December 2016 are:

- HR: Mandatory Training Rate at 92% against a target of >= 95%
- HR: Appraisals & PDR Rate at 87% against a target of >= 90%
- HR: Staff Turnover Rates at 13% against a target of <= 10%

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

# Performance Summary - Trust Board - Month 9 - December 2016

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

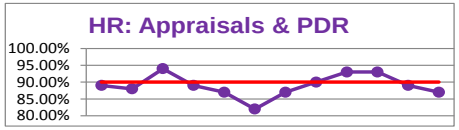



**HR: Sickness & Absence Rates at 5.3% against a target of <= 4.5%**

The split between short and long term sickness remains constant at approximately 40/60% . The 3 most common causes for sickness absence in December were:-

| | | |
|---|---|---|
| 1st | anxiety, stress or depression | (up from 2nd place in November) |
| 2nd | gastrointestinal problems | (down from 1st place in November) |
| 3rd | cold, cough or flu. | (same position) |

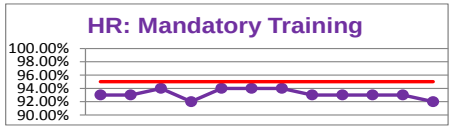
It is of concern that anxiety, stress or depression are the main cause for sickness absence and managers are continuing to work closely with their HR teams to ensure that individual cases are managed appropriately, that staff are managed on the appropriate stages and that staff are supported in returning to work as soon as is appropriate. It is anticipated that these actions will reduce sickness & absence levels to below Trust target rate before the end of Quarter 4.




**HR: Appraisals and PDR Rate at 87% against a target of >= 90%**

Ten areas are rated as amber – Genetics, Gynaecology, Imaging, Integrated Governance, Maternity, Medical, Neonates, Pharmacy, Surgical Services and Trust Offices whilst one area remains Red, Transport. The remaining 6 areas are rated Green.

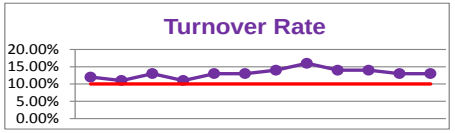
The L&D and HR teams continue to provide detailed information to managers with regards to PDR compliance in their areas of responsibility. Ongoing workshops are scheduled for managers and reviewees.




**HR: Mandatory Training Rates at 92% against a target of >= 95%**

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 has been an issue with the unavailability of conflict resolution training. A program of training for internal trainers is being put in place to address this.

Mandatory training compliance has been discussed at SMT, and Neonates have agreed to submit a paper to SMT and Execs asking for a review of headroom as they feel this is currently insufficient to allow the completion of the required mandatory training.
Efforts are on-going to reach the overall mandatory training target of 95%, and it is anticipated the target will be reached by the end of quarter four.




**HR: Staff Turnover Rates at 13% against a target of <= 10%**

There are 13 departments rated as red, 2 as amber and the remaining 2 as green. the total number of leavers in December was 11 (the same as in November). Work is being undertaken with Theatres to formulate a specific recruitment and retention strategy to address the continuing concerns with their level of turnover.

Managers are provided with detailed information on turnover by the Human Resources Department so that they can identify any concerns and any potential impact of Future Generations will continue to be monitored.

Having been consistently been above the 10% target since September 2015, it is likely that this trend will continue for the foreseeable future, however HR and the Services are endeavouring to bring the figure under target by the end of Quarter Four.

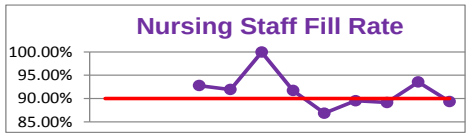
All Linear graphs are rolling 12 months

# Performance Summary - Trust Board - Month 9 - December 2016

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

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

## To deliver SAFER services




**Nursing Staff Fill rate at 89% against a Target of >= 90%**

Vacancies, sickness absence and maternity leave has impacted upon actual staff available. Increased short term sickness influences the number of staff available on a day by day basis affecting the number of available midwives.

The vacancy rate is monitored closely and the recruitment process is commenced as soon as is possible to reduce the potential of any delays and the Trust has extended its resignation period to 8 weeks.

Recruitment occurred in October and these staff are filtering into the system, a further two new starts are planned in the next couple of months. Vacancies have now been signed off by the Trust Board and therefore will enable us to go out to advert to cover further vacancies.

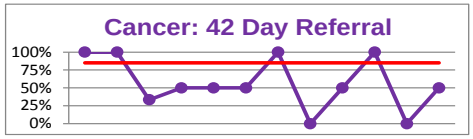
Staffing is reviewed across the whole service including maternity leave and the trust is proactive in supporting any maternity leave to cover any shortfall in staffing.

Sickness is managed by the Ward managers in a proactive manner in line with Trust policy

Off duty formulation is undertaken in a timely manner and additional staffing is sought where it falls below the level expected.

It is expected that the target will be achieved in March 2017. This will allow for additional staff in the recruitment to be in post, and will enable us to go out for further recruitment.

## To deliver the most EFFECTIVE outcomes




**Cancer 42 Day Referral onto treating Trust at 50% against a target of 85%**

2 patient breached the target against a total of 4 patients within this metric

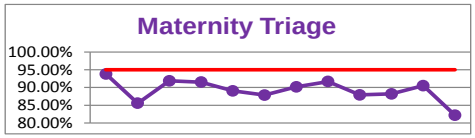
Following diagnosis, MDT required additional inpatient diagnostic procedures to stage cancer and determine treatment. This second round of post diagnosis procedures and MDT discussion resulted in final treatment plan (and subsequent onwards referral) being delayed past day 42 of patient pathway.

Patient required multiple biopsies to identify cancer site and type (inc. 1 inpatient diagnostic procedure). An immunohistochemical study was also done on one biopsy. The difficulty in establishing diagnosis and (2x) additional MDT discussions resulted in final treatment plan (and subsequent onwards referral) being delayed past day 42 of patient pathway.

Due to the small numbers involved and the lack of a tolerance in this measure we cannot identify a timescale of when the target will be achieved.

# Performance Summary - Trust Board - Month 9 - December 2016

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




**Maternity Triage within 30 Minutes at 82.2% against a target of >= 95%**

The organisation's aim is to see all women attending the MAU within 30 minutes of arrival; at times this is not always achieved. Of the 871 women seen in the MAU in December 2016, 170 breached the 30 minute target. The reasons for this are as follows:

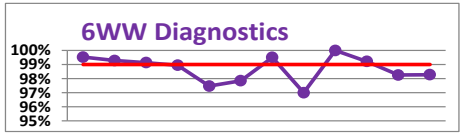
- High numbers of patients arriving in short space of time or at the same time, so unable to meet triage time for all within 30 mins.
- Medical staff busy on other areas or being pulled away by intrapartum area or theatre, resulting in MAU becoming bed blocked so reducing the flow of patients through the unit.
- Junior medical staff unable to make decisions, having to refer to seniors causing MAU to be bed blocked.
- Medical staff not answering bleeps- busy in other areas.
- High levels of activity on other areas, causing long waits for beds in other areas, causing MAU to be blocked.
- Out of hours the Maternity Day Unit women are seen by MAU, the numbers are variable but put additional pressure on the MAU.
- Some women who require scan review or a CTG are also asked to attend the MAU additional pressure.

To help resolve these issues :-

- Women are reviewed via telephone call and are seen in order of their individual risk assessment. This at time make compliance with the target more difficult but will keep patients safe.
- a new manager to start 01/2/2017.
- MAU still under review to open a second triage room, allowing more than one woman to be triaged at one time.
- Staffing model review to ensure staff in place during periods of high activity, better working hours.
- Discharge lounge commence 09/01/2017 which will free up beds on Matbase and allow better patient flow through MAU when patients need to be moved.
- A Consultant is now present on the MAU during day time hours to try and reduce delays and support juniors with decision making

The target will be achieved from March 2017. This timeframe will allow the new manager to settle into post and facilitate appropriate changes when possible along with Engagement with staff, Identifying location of second triage room and await process review for MAU redesign.

Furthermore, the Service intends to review this performance indicator for next year with a view of making sure that it is both the correct and more clinically appropriate indicator.




**6 Week Wait for Diagnostic Tests at 98.3% against a target of >= 99%**

The vacancy for urogynae consultant was filled at the end of November and has therefore added additional capacity for cystometery appointments. This has also released another gynae consultant from sessions who is also backfilling some additional sessions to support services at times of pressure.

Some nurse cystometery clinics are also being supported with the backfill by Consultant Nurses to support the services. This is being constantly monitored and patients are being partially booked to ensure that patients are seen in order of request date.

# Performance Summary - Trust Board - Month 9 - December 2016

## Emerging Concerns

There are no emerging concerns from December 2016.

## Conclusion

Overall, for December 2016 performance has dipped in comparison to November 2016. 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 , Unplanned Re-attendances to A&E, and Malnutrition Care Plans. It is anticipated that overall performance will improve when reporting January's position although some of the KPI's that the Trust has failed to achieve through the year will continue to be of concern through to the end of the financial year.

## 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 | | | |
| 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% | | | |
| HR: Annual Appraisal and PDR | | >= 90% | 89.00% | 87.00% | 82.00% | 87.00% | 90.00% | 92.00% | 90.00% | 89.00% | 87.00% | | | |
| HR: Completion of Mandatory Training | | >= 95% | 92.00% | 94.00% | 94.00% | 94.00% | 93.00% | 93.00% | 93.00% | 93.00% | 92.00% | | | |
| HR: Turnover Rate | | <= 10% | 11.00% | 13.00% | 13.00% | 14.00% | 16.00% | 14.00% | 14.00% | 13.00% | 13.00% | | | |

## 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 | | | |
| 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 | | | |
| 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 | | | |
| 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 | | | |
| Monitor: Financial Sustainability Risk Rating: Capital Cover | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 4 | 4 | 4 | | | |
| Monitor: Financial Sustainability Risk Rating: Liquidity | | 2 (1 from Sep 2016) | 2 | 2 | 1 | 1 | 1 | 1 | 4 | 4 | 4 | | | |
| Monitor: Financial Sustainability Risk Rating: I & E Margin | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 4 | 4 | 4 | | | |
| Monitor: Financial Sustainability Risk Rating: Variance to Plan | | 4 | 4 | 4 | 4 | 3 | 3 | 4 | 1 | 1 | 1 | | | |
| Monitor: Financial Sustainability Risk Rating: Overall Score | | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | | | |
| Monitor: Financial Sustainability Risk Rating: Agency Cap | | 0 | 51 | 25 | 57 | 88 | 75 | 68 | 138 | 177 | 136 | | | |

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% | | | |
| Serious Incidents: Number of Open SI's | | Monitoring Only | 23 | 23 | 20 | 20 | 20 | 19 | 21 | 17 | 20 | | | |
| Serious Incidents: Number of New SI's | | Monitoring Only | 1 | 2 | 4 | 2 | 2 | 2 | 5 | 3 | 5 | | | |
| % 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% | | | |
| Neonatal Bloodstream Infection Rate | | TBD | 0.11 | 0.00 | 0.00 | 1.30 | 2.70 | 1.30 | 0.00 | 0.00 | 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% | | | |
| Biochemical Pregnancy Rates | | > 30% TBC | 45.94% | 47.62% | 46.21% | 44.70% | 47.13% | 48.63% | 45.58% | 45.13% | 54.00% | | | |
| 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 | | | |
| Neonatal Deaths (all live births within 28 days) | | Rate per 1000 TBD | 1.44 | 2.90 | 6.65 | 1.33 | 2.66 | 5.17 | 0.00 | 2.92 | #DIV/0! | | | |
| Returns to Theatre | | <= 0.7% TBC | 0.64% | 1.03% | 0.50% | 0.51% | 0.22% | 0.21% | 0.32% | 0.56% | 0.74% | | | |

## 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% | | | |
| Number of Complaints received | | <= 15 | 15 | 5 | 13 | 18 | 13 | 19 | 16 | 10 | 8 | | | |
| 18 Week RTT Incompletes (aggregate) | | >= 92% | 95.71% | 95.90% | 93.86% | 95.20% | 94.28% | 92.63% | 92.20% | 93.03% | 92.86% | | | |
| Friends & Family Test | | > 75% | 99.26% | 98.47% | 98.60% | 97.52% | 98.37% | 99.11% | 98.51% | 97.85% | 98.78% | | | |
| % 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% | | | |
| % 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% | | | |
| 6 Week Wait Diagnostic Tests | | >= 99% | 98.96% | 97.47% | 97.85% | 100% | 97.00% | 100% | 99.22% | 98.26% | 98% | | | |
| Last Minute Cancellation for non-clinical reasons | | <= 4% | 4.30% | 6.31% | 5.81% | 5.01% | 4.79% | 4.20% | 2.64% | 5.28% | 4.40% | | | |
| Last Minute Cancellation for non-clinical reasons (Not re-admitted within 28 days) | | 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% | Not Available | Not Available | Not Available | Not Available | | | |

Liverpool Women's NHS Foundation Trust

# Safe Staffing Report Month 9 - December 2016

| Ward | RN/RM | | | Unqualifed | | | 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 1 | 100.0% | 98.4% | 5.1 | 111.1% | 103.0% | 8.1 | 3.41% | 17% | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 13 | 100% |
| *Narrative* | Recruiting to Band 6 HDU practitioner post wte 0.92. Shortlisted and interview booked for the 02/02/17. wte 1 x 0.92 banf 5 vacancy due to retirement and 1 x wte 0.3 band 5 vacancy due to retire and return. Not recruiting to band 5 posts currently due to ward re-design | | | | | | | | | | | | | | | | | | | | |
| Gynae 2 | 93.3% | 98.8% | 5.8 | 90.0% | 96.8% | 8.2 | 4.04% | 16% | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 3 | 17 | 100% |
| *Narrative* | Sickness - Band 5 staff nurse x 1 on long term sick following surgery. Maternity Leave - Band 5 staff nurse x 4 on maternity leave Vacancies - Band 5 nursing posts x 4 vacant. Not recruiting currently due to inpatient redesign project. Drug Error - IV fluids administered without Px. SBAR, Action plan and training in place for incident. There are currently 3 complains relating to 1; the method of discharge for 1 patient, 2; an unsatisfactory patient experience and 3; administritive prossecces. | | | | | | | | | | | | | | | | | | | | |
| Delivery & Induction Suites | 92.7% | 86.6% | 26.3 | 85.2% | 95.7% | 31.0 | 7.63% | 0% | | | 9 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 16 | 93.75% |
| *Narrative* | Staff sickness is higher than the recommended sickness rate for the Trust. The sickness has decreased this month and all staff are being appropriatley managed bt the ward manager and in accordance with the trust sickness and abvscence policy. There was 1 drug error this hads been managed by the ward manager. | | | | | | | | | | | | | | | | | | | | |
| Mat Base | 86.7% | 85.1% | 3.7 | 122.6% | 83.9% | 5.7 | 12.67% | 2% | | | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 4 | N/A | |
| *Narrative* | The manager monitors sickness via the sickness and absence policy and meets regularly with HR to ensure the Policy is followed. The sickness rate should improve in the next report as most staff are back at work. The fall was investigated by the manager. The fall was due to a patient who became dizzy on mobilising. There were no health and safety issues identified and the patient did not sustain any injuries and was reviewed appropriately. Th emedication erros have been reviewed by the manager and discussed with the individuals and the team. The issues surrounded documentation and there were no harm to patients as a result of errors. The midwives are tasked with reflecting learning from the incidents to avoid reoccurence. Any serious incidents or reoccuring themes from staff memebers would be dealt with through the disciplinary policy. Themes from complaints are identified and discussed with the individuals involved and also with the wider team through meetings so learning can be identified. Any complaints which involve staff behaviour or attitude are being monitored and staff involved are being sent on customer care training. | | | | | | | | | | | | | | | | | | | | |
| MLU & Jeffcoate | 77.4% | 77.9% | 31.5 | 50.0% | 51.6% | 37.4 | 6.27% | 8% | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | N/A | |
| *Narrative* | During the month of december staffing numbers were reduced on MLU, this was due to sickness and staff being redeployed to other areas. MLU remained safe and care was not compromised | | | | | | | | | | | | | | | | | | | | |
| NICU | 103.8% | 99.8% | 11.4 | 51.6% | 51.6% | 12.1 | 6.81% | 12% | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | 0 | 0 | |
| *Narrative* | The planned numbers refelected in the safer staffing model are currently aspirational numbers to achieve the BAPM standard. The level of staffing on the NICU have greatly improved with positive recruitment and safe staffing levels have been maintained with minimal bank input. The baseline figures will be reviewed and reset to appropriately reflect what safe staffing are on the NICU. | | | | | | | | | | | | | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| *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:** | 2017/038 |

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

| | |
|---|---|
| **Date:** | 3 February 2017 |

| | |
|---|---|
| **Title:** | Month 9 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 9 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

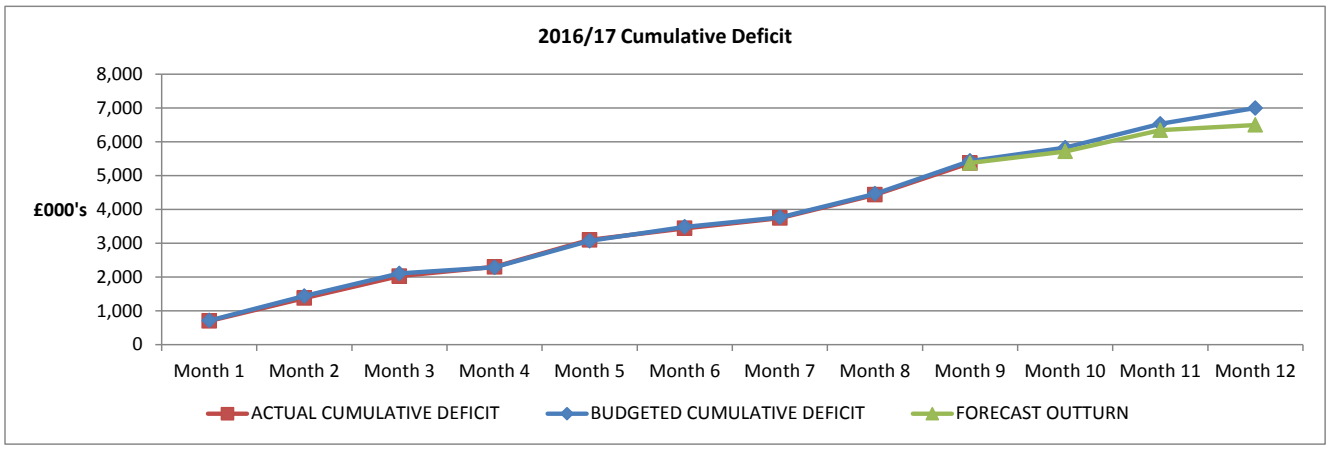
The 2016/17 budget was approved at Trust Board in April 2016. This set out a deficit of £7m for the year (as per the control total set out by NHS Improvement), an FSRR[1] of 2 and a cash shortfall of £7.7m. This planned position assumes receipt in full of £2.8m Sustainability and Transformation Funding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

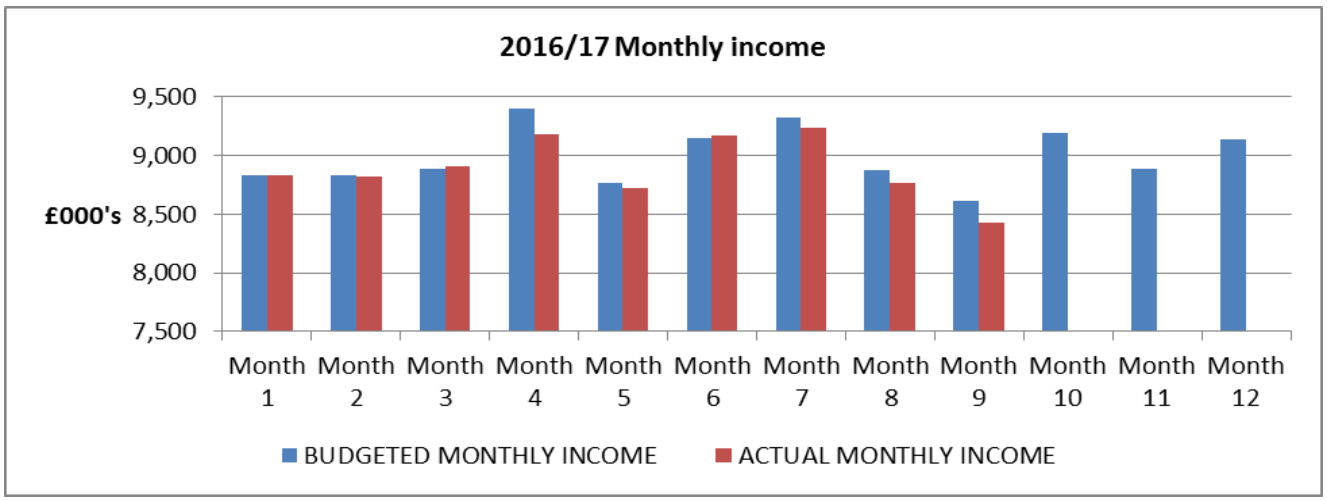
At Month 9 the Trust is reporting a monthly deficit of £0.945m against a deficit plan of £0.971m which is a positive variance of £0.026m for the month. Cumulatively the Trust is ahead of plan by £0.057m on a year to date budget of £5.43m deficit.

The Trust is on track to deliver the overall 2016/17 control total. Following a detailed review at Month 9 the Trust is now in a position to improve the forecast deficit to £6.5m.

## 2. Summary 2016/17 Financial Position

At Month 9 the Trust is reporting a £5.37m deficit against a plan of £5.43m and is forecasting a £6.5m deficit for the year as summarised below.




In month income remains below plan predominantly as a result of the Hewitt Fertility Centre shortfall.

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

The Trust has agreed a fixed level of income for the rest of the financial year with Liverpool, St Helens and Knowsley CCGs.

Pay expenditure overall remains below budget predominantly due to vacancies across a number of services including neonates, Hewitt Centre and genetics.

Non-pay expenditure is forecast to be above plan predominantly due to the non-delivery of CIP in gynaecology/theatres.

## 3. Service Review

**Maternity**
Maternity Services remain on track to out-perform budget in 2016/17. Deliveries are the main driver of income out-performance, which is being partly offset by activity-related expenditure.

**Gynaecology and Theatres**
Gynaecology activity is forecast to be ahead of plan overall, predominantly across general gynaecology. However, agency costs in theatres and the non delivery of CIP in year more than offset this. Both theatres agency and CIP are under scrutiny by the Turnaround and Transformation Committee to ensure the required levels of delivery in 2017/18.

**Neonates**
Neonates is forecast to outperform budget following the receipt of non-recurrent monies from Health Education England and an improvement in the Welsh income position.

**Hewitt Fertility Centre (HFC)**
The HFC financial position remains impacted by three key issues

a) Deterioration of the North West business
b) Non-delivery of the Kings Joint Venture contribution (CIP scheme) and subsequent losses
c) Slippage in the delivery of the recovery plans

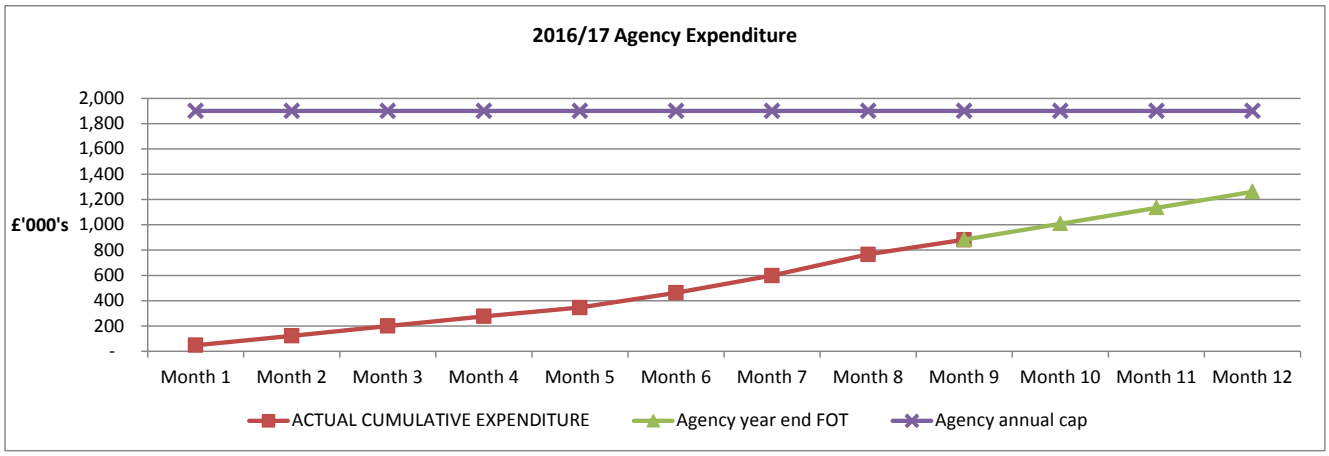
The financial impact to date is a net £1.1m behind plan with a projected £1.3m full year shortfall. The position includes some mitigations already put in place and takes into account the further loss of planned activity and the share of a loss in relation to the Kings Joint Venture.

HFC is currently being scrutinised by Non-Executive Director-chaired Hewitt Oversight Board, and additional turnaround support has been pointed towards this area.

**Genetics**
Genetics income is behind plan year to date as a result of underperformance on the 100,000 genomes contract and decreased lab activity due to staff shortages. However, some of the income shortfall is offset by a reduction in pay costs, and the ongoing impact of vacancies. It is expected that some of this income will be recovered in the latter part of the year.

## 4. Agency Spend

The chart below illustrates the level of agency spend against budget and in terms of the agency cap set for the Trust.




The Trust remains the third highest performing in the North region in terms of meeting the agency caps set by NHSI.

## 5. Forecast Outturn and Out-Performance of 2016/17 Control Total

Following detailed review at Month 9, it is forecast that the Trust will outperform the control total by £0.5m. This is as a result of;

- A more certain income position as noted above
- A review of the Trust's holiday pay provision
- A reduction in bank and agency spend following the ongoing implementation of e-roster

The movement in the forecast since Month 8 is summarised as follows:

| | £m |
|---|---|
| **Forecast Deficit at Month 8** | **(7.0)** |
| Improvement in income forecast | 0.3 |
| Release of holiday pay provision | 0.1 |
| Reduction in bank and agency spend forecast | 0.1 |
| **Forecast Deficit at Month 9** | **(6.5)** |

The improvements to the position are on a non-recurrent basis in year arising from 'one off' gains, and do not impact on the following year's plans, or are already part of the Trust's future CIP plans.

NHS Improvement have informed the Trust of a national incentive scheme whereby, if a Trust can deliver a financial position better than its planned control total, it can apply for STF incentive funding. This means that for every £1 delivered over and above the control total the Trust will receive £1 additional revenue from the STF incentive fund. Whilst this funding is aimed at improving the bottom line financial position of the Trust, it is received in the form of cash which is of benefit to the Trust.

This impacts on the deficit as follows:

| | £m |
|---|---|
| **Control Total Deficit** | **(7.0)** |
| Trust Forecast Improvement | 0.5 |
| STF incentive matched revenue | 0.5 |
| **Forecast Overall Trust Deficit 16/17** | **(6.0)** |

The above position has been notified to NHSI as part of the monthly and quarterly returns.

## 6. CIP Delivery

The Trust has an annual CIP target in 2016/17 of £2m, which represents c2% of the Trust's income. This is made up of ten schemes and has been transacted through the ledger as part of budget setting.

Under-delivery of the ten identified CIP schemes is £1m for the full year. This arises from two schemes each valued at £0.5m, Hewitt Fertility Centre Growth and Theatre/Inpatient redesign. Non-recurrent mitigations at a Trust level are in place and significant focus has been placed in these two areas to minimise the impact on future years.

## 7. Cash and borrowings

During 2015/16 the Trust was in receipt of £5.6m Interim Revenue Support from the Department of Health (DH). This is 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. The Trust has been utilising a pre-arranged DH working capital facility, and at month 9 had drawn down £3.0m in cash support from this.

On 17 January 2017 NHSI indicated that those trusts on track to deliver their control total in the Month 9 forecast position would be eligible for a decrease in the interest rate levied from 3.5% to 1.5% by converting the working capital facility into interim revenue support. The Trust has applied for the conversion with a view to this taking place on 30 January 2017.

The cash balance as at the end of Month 9 was £4.5m.

## 8. BAF Risk

As a result of the improvement in the forecast position it is recommended that the BAF risk 5aii in relation to the non-achievement of the 2016/17 control total should be reduced.

This currently stands at 20 (probable and catastrophic) and it is proposed that this be reduced to 15 (possible and catastrophic).

## 9. Conclusion & Recommendation

The Board are asked to note the Month 9 financial position, the improved forecast and the availability of STF incentive funding.

The Board are also asked to approve the conversion of the Trust's working capital facility to interim revenue support.

## Appendix 1 – Board pack

Board Finance Pack M9.xlsx

## Appendix 2 - Single Oversight Framework - Use of Resources Rating

| USE OF RESOURCES RISK RATING | YEAR TO DATE Budget | YEAR TO DATE Actual | YEAR Budget | YEAR FOT |
|---|---|---|---|---|
| **CAPITAL SERVICING CAPACITY (CSC)** | | | | |
| **(a)** EBITDA + Interest Receivable | (480) | (767) | (400) | (517) |
| **(b)** PDC + Interest Payable + Loans Repaid | 1,881 | 1,701 | 2,712 | 2,387 |
| **CSC Ratio = (a) / (b)** | **(0.26)** | **(0.45)** | **(0.15)** | **(0.22)** |
| **NHSI CSC SCORE** | **4** | **4** | **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 | (5,285) | (4,723) | (8,924) | (8,924) |
| **(b)** Expenditure | 81,167 | 80,855 | 108,297 | 107,573 |
| **(c)** Daily Expenditure | 301 | 299 | 301 | 299 |
| **Liquidity Ratio = (a) / (c)** | **(17.6)** | **(15.8)** | **(29.7)** | **(29.9)** |
| **NHSI LIQUIDITY SCORE** | **4** | **4** | **4** | **4** |
| **Ratio Score** **1** = > 0 **2** = (7) - 0 **3** = (14) - (7) **4** = < (14) | | | | |
| **I&E MARGIN** | | | | |
| Deficit (Adjusted for donations and asset disposals) | 5,425 | 5,371 | 6,992 | 6,500 |
| Total Income | (80,305) | (80,395) | (107,387) | (107,045) |
| **I&E Margin** | **-6.76%** | **-6.68%** | **-6.51%** | **-6.07%** |
| **NHSI I&E MARGIN SCORE** | **4** | **4** | **4** | **4** |
| **Ratio Score** **1** = > 1% **2** = 1 - 0% **3** = 0 - (-1%) **4** < (-1%) | | | | |
| **I&E MARGIN VARIANCE FROM PLAN** | | | | |
| I&E Margin (Actual) | | -6.68% | | -6.07% |
| I&E Margin (Plan) | | -6.76% | | -6.51% |
| **I&E Variance Margin** | **0.00%** | **0.07%** | **0.00%** | **0.44%** |
| **NHSI I&E MARGIN VARIANCE SCORE** | **1** | **1** | **1** | **1** |
| **Ratio Score** **1** = > 0% **2** = (1) - 0% **3** = (2) - (1)% **4** = < (2)% | | | | |
| **AGENCY SPEND** | | | | |
| **YTD Providers Cap** | 1,443 | 1,443 | 1,924 | 1,924 |
| **YTD Agency Expenditure** | 450 | 879 | 600 | 1,260 |
| | **-68.81%** | **-39.08%** | **-68.81%** | **-34.51%** |
| **NHSI AGENCY SPEND SCORE** | **1** | **1** | **1** | **1** |
| **Ratio Score** **1** = < 0% **2** = 0% - 25% **3** = 25% - 50% **4** = > 50% | | | | |
| **Overall Use of Resources Risk Rating** | **3** | **3** | **3** | **3** |

**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.**

**Note: scoring a 4 on any of the metrics will lead to a financial override score of 3.**

# LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

# FINANCE REPORT: M9

# YEAR ENDED 31 MARCH 2017

## Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M09
YEAR ENDED 31 MARCH 2017



| USE OF RESOURCES RISK RATING | YEAR TO DATE Budget | YEAR TO DATE Actual | YEAR Budget | YEAR FOT |
|---|---|---|---|---|
| **CAPITAL SERVICING CAPACITY (CSC)** | | | | |
| **(a)** EBITDA + Interest Receivable | (480) | (767) | (400) | (517) |
| **(b)** PDC + Interest Payable + Loans Repaid | 1,881 | 1,701 | 2,712 | 2,387 |
| **CSC Ratio = (a) / (b)** | **(0.26)** | **(0.45)** | **(0.15)** | **(0.22)** |
| **NHSI CSC SCORE** | **4** | **4** | **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 | (5,285) | (4,723) | (8,924) | (8,924) |
| **(b)** Expenditure | 81,167 | 80,855 | 108,297 | 107,573 |
| **(c)** Daily Expenditure | 301 | 299 | 301 | 299 |
| **Liquidity Ratio = (a) / (c)** | **(17.6)** | **(15.8)** | **(29.7)** | **(29.9)** |
| **NHSI LIQUIDITY SCORE** | **4** | **4** | **4** | **4** |
| **Ratio Score** **1** = > 0 **2** = (7) - 0 **3** = (14) - (7) **4** = < (14) | | | | |
| **I&E MARGIN** | | | | |
| Deficit (Adjusted for donations and asset disposals) | 5,425 | 5,371 | 6,992 | 6,500 |
| Total Income | (80,305) | (80,395) | (107,387) | (107,045) |
| **I&E Margin** | **-6.76%** | **-6.68%** | **-6.51%** | **-6.07%** |
| **NHSI I&E MARGIN SCORE** | **4** | **4** | **4** | **4** |
| **Ratio Score** **1** = > 1% **2** = 1 - 0% **3** = 0 - (-1%) **4** < (-1%) | | | | |
| **I&E MARGIN VARIANCE FROM PLAN** | | | | |
| I&E Margin (Actual) | | -6.68% | | -6.07% |
| I&E Margin (Plan) | | -6.76% | | -6.51% |
| **I&E Variance Margin** | **0.00%** | **0.07%** | **0.00%** | **0.44%** |
| **NHSI I&E MARGIN VARIANCE SCORE** | **1** | **1** | **1** | **1** |
| **Ratio Score** **1** = > 0% **2** = (1) - 0% **3** = (2) - (1)% **4** = < (2)% | | | | |
| **AGENCY SPEND** | | | | |
| **YTD Providers Cap** | 1,443 | 1,443 | 1,924 | 1,924 |
| **YTD Agency Expenditure** | 450 | 879 | 600 | 1,260 |
| | **-68.81%** | **-39.08%** | **-68.81%** | **-34.51%** |
| **NHSI AGENCY SPEND SCORE** | **1** | **1** | **1** | **1** |
| **Ratio Score** **1** = < 0% **2** = 0% - 25% **3** = 25% - 50% **4** = > 50% | | | | |
| **Overall Use of Resources Risk Rating** | **3** | **3** | **3** | **3** |

**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.**

**Note: scoring a 4 on any of the metrics will lead to a financial override score of 3.**

**LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**
**INCOME & EXPENDITURE: M9**
**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 | YEAR Budget | YEAR FOT | YEAR Variance |
|---|---|---|---|---|---|---|---|---|---|
| **Income** | | | | | | | | | |
| Clinical Income | (8,035) | (7,849) | (186) | (75,425) | (75,371) | (54) | (100,881) | (100,351) | (531) |
| Non-Clinical Income | (584) | (583) | (1) | (5,254) | (4,705) | (550) | (7,006) | (6,694) | (312) |
| **Total Income** | **(8,618)** | **(8,432)** | **(187)** | **(80,680)** | **(80,076)** | **(604)** | **(107,887)** | **(107,045)** | **(842)** |
| **Expenditure** | | | | | | | | | |
| Pay Costs | 5,613 | 5,497 | 115 | 50,513 | 49,801 | 711 | 67,352 | 66,297 | 1,055 |
| Non-Pay Costs | 2,235 | 2,225 | 10 | 19,924 | 20,323 | (399) | 26,638 | 26,968 | (330) |
| CNST | 1,192 | 1,192 | 0 | 10,730 | 10,730 | 0 | 14,307 | 14,308 | (1) |
| **Total Expenditure** | **9,040** | **8,914** | **126** | **81,167** | **80,855** | **312** | **108,297** | **107,573** | **724** |
| **EBITDA** | **422** | **483** | **(61)** | **487** | **779** | **(292)** | **410** | **528** | **(119)** |
| **Technical Items** | | | | | | | | | |
| Depreciation | 375 | 322 | 53 | 3,375 | 3,211 | 165 | 4,500 | 4,217 | 284 |
| Interest Payable | 35 | 10 | 25 | 315 | 217 | 98 | 420 | 232 | 188 |
| Interest Receivable | (1) | (1) | 0 | (7) | (12) | 4 | (10) | (12) | 2 |
| PDC Dividend | 140 | 131 | 9 | 1,260 | 1,178 | 82 | 1,680 | 1,543 | 137 |
| Profit / Loss on Disposal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Technical Items** | **549** | **462** | **87** | **4,943** | **4,594** | **349** | **6,590** | **5,980** | **611** |
| **(Surplus) / Deficit** | **971** | **945** | **26** | **5,430** | **5,373** | **57** | **7,000** | **6,508** | **492** |

**LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**
**EXPENDITURE: M9**
**YEAR ENDED 31 MARCH 2017**

| EXPENDITURE £'000 | MONTH Budget | MONTH Actual | MONTH Variance | YEAR TO DATE Budget | YEAR TO DATE Actual | YEAR TO DATE Variance | YEAR Budget | YEAR FOT | YEAR Variance |
|---|---|---|---|---|---|---|---|---|---|
| **Pay Costs** | | | | | | | | | |
| Board, Execs & Senior Managers | 337 | 338 | (1) | 3,035 | 3,036 | (0) | 4,047 | 4,024 | 23 |
| Medical | 1,271 | 1,210 | 60 | 11,436 | 11,174 | 261 | 15,248 | 14,715 | 533 |
| Nursing & Midwifery | 2,504 | 2,430 | 74 | 22,535 | 21,885 | 650 | 30,047 | 29,137 | 911 |
| Healthcare Assistants | 391 | 359 | 32 | 3,518 | 3,506 | 12 | 4,691 | 4,671 | 21 |
| Other Clinical | 543 | 506 | 36 | 7,470 | 7,167 | 304 | 6,513 | 6,039 | 474 |
| Admin Support | 159 | 163 | (4) | 1,430 | 1,500 | (71) | 1,906 | 1,999 | (93) |
| Corporate Services | 358 | 375 | (17) | 639 | 654 | (16) | 4,299 | 4,452 | (153) |
| Agency & Locum | 50 | 115 | (65) | 450 | 879 | (429) | 600 | 1,260 | (660) |
| **Total Pay Costs** | **5,613** | **5,497** | **115** | **50,513** | **49,801** | **711** | **67,352** | **66,297** | **1,055** |
| **Non Pay Costs** | | | | | | | | | |
| Clinical Suppplies | 732 | 729 | 3 | 6,634 | 6,691 | (56) | 8,858 | 8,908 | (49) |
| Non-Clinical Supplies | 622 | 628 | (6) | 5,357 | 5,756 | (398) | 7,203 | 7,616 | (413) |
| CNST | 1,192 | 1,192 | 0 | 10,730 | 10,730 | 0 | 14,307 | 14,308 | (1) |
| Premises & IT Costs | 415 | 407 | 8 | 3,737 | 3,718 | 19 | 4,983 | 4,969 | 15 |
| Service Contracts | 466 | 461 | 5 | 4,195 | 4,159 | 37 | 5,594 | 5,476 | 118 |
| **Total Non-Pay Costs** | **3,428** | **3,417** | **10** | **30,654** | **31,053** | **(399)** | **40,945** | **41,276** | **(331)** |
| **Total Expenditure** | **9,040** | **8,914** | **126** | **81,167** | **80,855** | **312** | **108,297** | **107,573** | **724** |

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M9
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 | YEAR Budget | YEAR FOT | YEAR Variance |
|---|---|---|---|---|---|---|---|---|---|
| **Maternity** | | | | | | | | | |
| Income | (3,323) | (3,317) | (6) | (30,454) | (31,019) | 565 | (40,771) | (41,416) | 645 |
| Expenditure | 1,698 | 1,680 | 18 | 15,283 | 15,506 | (224) | 20,378 | 20,677 | (299) |
| **Total Maternity** | **(1,625)** | **(1,637)** | **12** | **(15,172)** | **(15,513)** | **341** | **(20,393)** | **(20,739)** | **345** |
| **Gynaecology** | | | | | | | | | |
| Income | (1,853) | (1,841) | (12) | (17,991) | (18,616) | 625 | (23,965) | (24,635) | 670 |
| Expenditure | 879 | 902 | (23) | 7,914 | 8,334 | (419) | 10,554 | 11,103 | (549) |
| **Total Gynaecology** | **(974)** | **(939)** | **(35)** | **(10,076)** | **(10,282)** | **206** | **(13,411)** | **(13,532)** | **120** |
| **Theatres** | | | | | | | | | |
| Income | (42) | (31) | (11) | (378) | (363) | (15) | (504) | (488) | (16) |
| Expenditure | 608 | 636 | (28) | 5,473 | 5,812 | (339) | 7,298 | 7,722 | (424) |
| **Total Theatres** | **566** | **605** | **(39)** | **5,095** | **5,449** | **(354)** | **6,794** | **7,234** | **(440)** |
| **Neonatal** | | | | | | | | | |
| Income | (1,409) | (1,439) | 30 | (12,681) | (12,435) | (247) | (16,908) | (16,935) | 28 |
| Expenditure | 997 | 1,022 | (25) | 8,975 | 8,806 | 169 | 11,967 | 11,814 | 153 |
| **Total Neonatal** | **(412)** | **(417)** | **5** | **(3,707)** | **(3,629)** | **(78)** | **(4,941)** | **(5,121)** | **180** |
| **Hewitt Centre** | | | | | | | | | |
| Income | (837) | (636) | (201) | (8,776) | (7,264) | (1,512) | (11,874) | (10,005) | (1,869) |
| Expenditure | 728 | 687 | 41 | 6,595 | 6,150 | 445 | 8,805 | 8,187 | 618 |
| **Total Hewitt Centre** | **(109)** | **51** | **(160)** | **(2,181)** | **(1,114)** | **(1,067)** | **(3,069)** | **(1,818)** | **(1,250)** |
| **Genetics** | | | | | | | | | |
| Income | (594) | (602) | 8 | (5,356) | (5,158) | (198) | (7,143) | (6,830) | (313) |
| Expenditure | 446 | 418 | 29 | 4,018 | 3,822 | 196 | 5,358 | 5,104 | 254 |
| **Total Genetics** | **(148)** | **(185)** | **37** | **(1,338)** | **(1,336)** | **(2)** | **(1,785)** | **(1,726)** | **(59)** |
| **Clinical Support** | | | | | | | | | |
| Income | (24) | (18) | (5) | (220) | (230) | 11 | (291) | (297) | 6 |
| Expenditure | 733 | 700 | 33 | 6,595 | 6,466 | 128 | 8,793 | 8,600 | 193 |
| **Total Clinical Support** | **709** | **681** | **28** | **6,375** | **6,236** | **139** | **8,502** | **8,303** | **199** |
| **Corporate & Trust Technical Items** | | | | | | | | | |
| Income | (536) | (547) | 11 | (4,824) | (4,992) | 168 | (6,432) | (6,440) | 8 |
| Expenditure | 3,500 | 3,331 | 168 | 31,257 | 30,553 | 704 | 41,735 | 40,345 | 1,390 |
| **Total Corporate** | **2,964** | **2,785** | **179** | **26,433** | **25,562** | **872** | **35,303** | **33,906** | **1,397** |
| **(Surplus) / Deficit** | **971** | **945** | **26** | **5,430** | **5,373** | **57** | **7,000** | **6,508** | **492** |

# LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
## BALANCE SHEET: M9
## YEAR ENDED 31 MARCH 2017

| BALANCE SHEET £'000 | YEAR TO DATE Opening | M09 Actual | Movement |
|---|---|---|---|
| **Non Current Assets** | **70,529** | **69,539** | (990) |
| **Current Assets** | | | |
| Cash | 3,225 | 4,490 | 1,265 |
| Debtors | 4,302 | 7,049 | 2,747 |
| Inventories | 326 | 283 | (43) |
| **Total Current Assets** | **7,853** | **11,822** | **3,969** |
| **Liabilities** | | | |
| Creditors due < 1 year | (8,056) | (13,987) | (5,931) |
| Creditors due > 1 year | (1,748) | (1,756) | (8) |
| Commercial loan | (10,794) | (13,489) | (2,695) |
| Provisions | (2,392) | (2,110) | 282 |
| **Total Liabilities** | **(22,990)** | **(31,342)** | (8,352) |
| **TOTAL ASSETS EMPLOYED** | **55,392** | **50,019** | **(5,373)** |
| **Taxpayers Equity** | | | |
| PDC | 36,610 | 36,610 | 0 |
| Revaluation Reserve | 10,019 | 10,019 | 0 |
| Retained Earnings | 8,763 | 3,390 | (5,373) |
| **TOTAL TAXPAYERS EQUITY** | **55,392** | **50,019** | **(5,373)** |

2017/038

Future Generations Update

| | |
|---|---|
| **Agenda item no:** | 2017/039 |

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

| | |
|---|---|
| **Date:** | 3 February 2017 |

| | |
|---|---|
| **Title:** | Board Assurance Framework & Corporate Risk Register Review |

| | |
|---|---|
| **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?** | **I**nformation | (✓) | **D**ecision | (✓) | **E**scalation | ( ) | **A**ssurance | (✓) |

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

| | |
|---|---|
| **Which CQC fundamental standard/s does this report relate to?** | Regulation 17 – Good governance |

| | |
|---|---|
| **What action is required at this meeting?** | a) approve the amendments to the BAF.<br>b) confirm that the BAF and the Corporate Risk Register adequately identify the principal risks to achieving the Trust's strategic objectives<br>c) confirm that the BAF and the Corporate Risk Register have adequate assurance systems in place. |

| | |
|---|---|
| **Presented by:** | Colin Reid, Trust Secretary |

| | |
|---|---|
| **Prepared by:** | Governance Team |

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 | |
| NHS constitution | | Operational 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 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 and summary

The Board Assurance Framework (BAF) is designed to provide the Board with an easily digestible overview of the principal risks relating to the strategic aims of the organisation. It highlights ownership and accountability through identification of the Executive Lead and of the Non-Executive via the associated Board Committee.

The BAF lists alongside each principal risk those associated risks that are being managed at service level or via the Corporate Risk Register. It is for the Board to form a view of their satisfaction with the assurance(s) provided and identify any gaps and actions they consider necessary.

## 2. Key Themes

Since the last meeting of the Board Directors the following sub-Committees of the Board have met and considered the BAF risks for which they are responsible:

Governance & Clinical Assurance Committee: 13 January 2017
No changes were recommended to the Board Assurance Framework risks for which GACA is responsible. As with other sub-committees GACA committed to implementing a revised BAF ahead of the Board of Directors meeting in April.

Putting People First Committee: 27 January 2017
The PPF Committee agreed to recommend the de-escalation of Risk 1909 (4c on the BAF) to the Corporate Risk register and introducing in its place a generic risk describing the potential for any of the Trust's staff to take industrial action.

It is felt this risk would be able to better describe the generic uncertainty industrial action presents to achieving the Trust's strategic aims and could then be supported by sub-risks that describe any specific emerging issues (as was the case regarding junior doctor action in 2016).

Finance, Performance & Business Development Committee: 30 January 2017
The FPBD Committee agreed to recommend that Risk 1748 (5c on the BAF) be closed. The plans to develop services nationally and internationally are no longer being progressed. As such any associated risks and uncertainty are no longer relevant.

It was identified at GACA that Risk 1928 (1n on the BAF) and Risk 1809 (1k on the BAF) had not previously been discussed at FPBD but were identified on the BAF as under the remit of this Committee. The FPBD in considering the risks felt that they were best placed within GACA in terms of the clinical impacts the risks had identified.

Corporate Risk Committee: January 2017
The Corporate Risk Committee agreed to accept Risks 2073 and 2074 onto the Corporate Risk Register. These risks reflected potential deficiencies in fire safety procedures and fire prevention that had been highlighted in a recent audit report.

Other Issues
The Trust conducted its latest biannual inspection against the CQC's fundamental standards in December. This review found that although the Risk Management framework was strong and there had been significant improvements made to the way in which the Board managed risk there were further improvements to be made, particularly increased evidence of discussion of risk.

In response the Executive Team have approved an action plan that requires all executives to fully review the Board Assurance Framework risks for which they are responsible and for a revised Board

Assurance Framework to be agreed by the Board in April. The revised BAF in April will include target risk scores and encourage more proactive management of controls, assurance and actions by risk owners and more challenge to this evidence from the responsible sub-Committees.

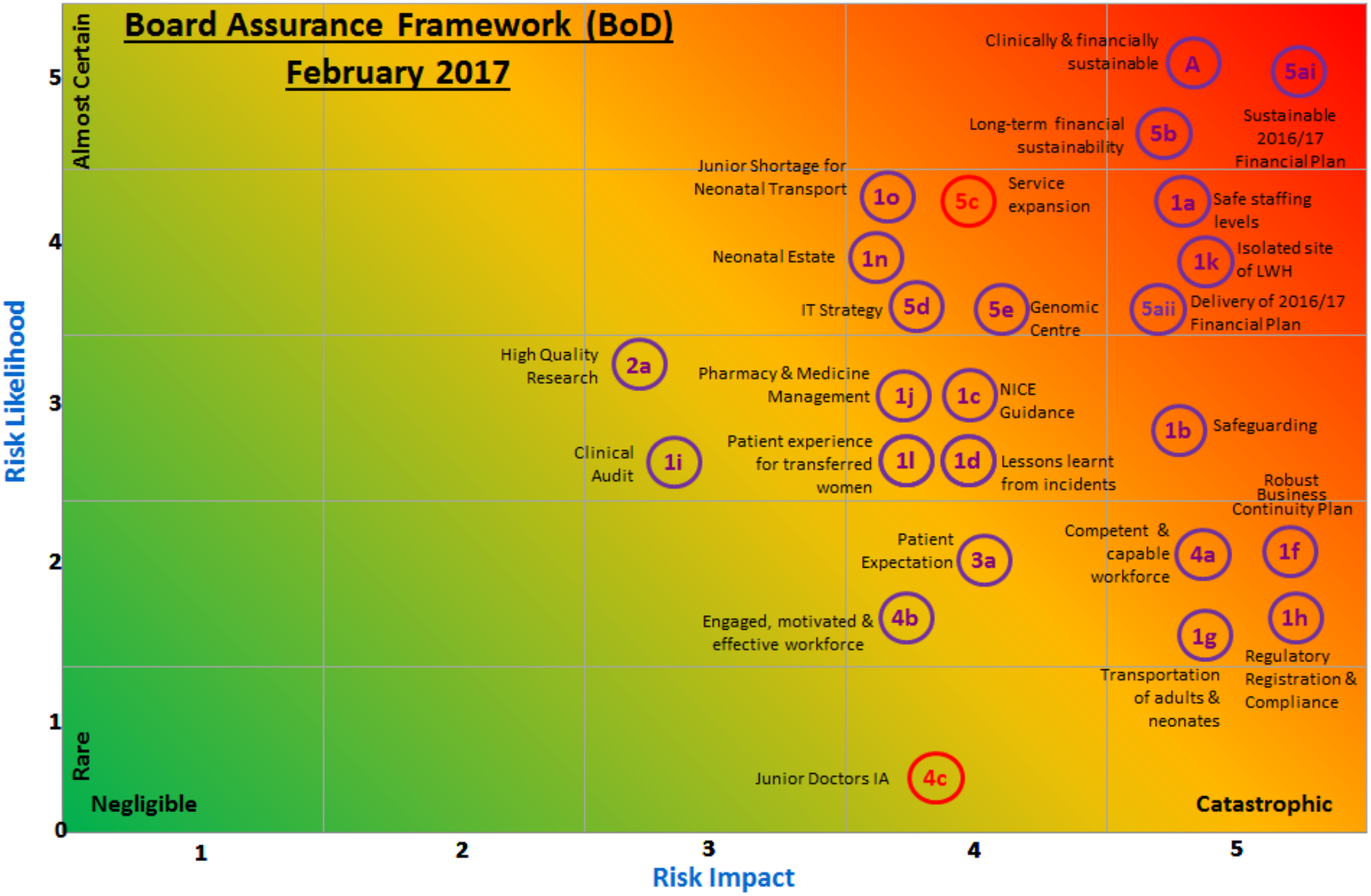
This review process is already underway with all sub-committee risks well on their way to being fully updated and thoroughly evidenced by April's Board meeting. The relevant Executives, or their deputies, have committed to a regular meeting with the Head of Governance in advance of each sub-committee meeting to ensure clear recommendations are always made.

## 3. Conclusions and Recommendations

It is recommended that, taking into account the review of the Corporate Risk Register, the Board:-

a) approve the amendments to the BAF recommended by the relevant Board Committees, namely GACA, FPBD and PPF.
b) confirm that the BAF and the Corporate Risk Register adequately identify the principal risks to achieving the Trust's strategic objectives
c) confirm that the BAF and the Corporate Risk Register have adequate assurance systems in place to ensure the systems of control were effective and efficient in controlling the risks identified and that appropriate actions are in place where required.

**Appendix 1 – Heat-map of BAF Risks**



## Appendix 2 – Full details of BAF Risks (currently under full review by sub-Committees)

**Strategic Aim & Reference –** A: Deliver Liverpool Women's Hospital strategic intention effectively and efficiently ensuring sustainable quality services through transitional arrangements

**Risk Target / Risk Appetite -** Significant

| Risk Description | ID of Sub-Risks | Enablers | Exec Lead (Responsible Committee) | Risk Level | | Key Controls/Mitigation Action | Assurance/Evidence | Gaps in Control/ Assurance Level? | Action | Date for Completion |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Initial | Current | | | | | |
| **A)** In order to be clinically and financially sustainable the Trust will need to undertake major change over an extended time period (five years).<br>**Risk**: (1) Failure to communicate clearly and effectively during a period of significant changes.<br>(2) Failure to maintain a focus on the operational delivery of services.<br>(3) Failure to attract and retain high calibre clinicians and managers.<br>**Cause**: This level of change will produce a period of uncertainty and then radical change, this will be a significant plan to implement within the Trust capacity.<br>**Effect**: (1) Difficulty in retaining public and staff confidence in Trust services.<br>(2) Activity related to this subject may distract from day-to-day activity and therefore quality of services could reduce.<br>3) Staff choose to seek alternative employment and difficulties recruiting.<br>**Impact**:<br>(1) Reputational damage.<br>(2) Failure to maintain quality standards and CQC compliance.<br>(3) Inability to deliver PPF.<br>**Ulysses Ref:1846** | 1906<br>1962 | Risk Management Strategy | Chief Exec (FPBD) | **5x5 =25** | **5x5= 25** | • Board leadership internally and externally<br>• Executive Oversight<br>• Consistent and cohesive message from Board of Directors<br>• Board approval of strategic options business plan and stakeholder communication and engagement strategy<br>• Appointment of Project Director and Project Clinical Lead.<br>• Establishment of Future Generations Project Board<br>• Project Mandate for governance and risk arrangements.<br>•Communication and Engagement strategy agreed and Head of Communication appointed<br>• Pro-active engagement in Healthy Liverpool Programme.<br>• Regular dialogue with Monitor & CQC and CCG.<br>• Support external consultants(PwC) | • November 2014- Business Plan<br>• December 2014 - Communications Plan<br>• Board & CoG agendas to include monthly project updates.<br>• Staff survey / Pulse survey scores as reflection of staff engagement<br>• Minutes of Future Generations Project Board<br>• Regular dialogue with Monitor & CQC and CCG.<br>• Chair & CEO activity update reports re networking and dialogues with external stakeholders. | Yes | CCG Options Appraisal<br>Public Consultation | July 2016<br>Dec 2016 |

**Strategic Aim & Reference –** 1: To deliver safe services

**Risk Target / Risk Appetite** - Low

| Risk Description | ID of Sub-Risks | Enablers | Exec Lead (Responsible Committee) | Risk Level | | Key Controls/Mitigation Action | Assurance/Evidence | Gaps in Control/ Assurance Level? | Action | Date for Completion |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Initial | Current | | | | | |
| **1a)** To ensure appropriate and safe staffing levels are maintained<br>**Risk:** Failure to have operational grip / effective utilisation of resource .<br>**Cause:** 1) insufficient investment in clinical staffing to meet recommended staffing levels associated with Maternity Tariff 2) high sickness absence levels in midwifery workforce<br>**Effect:** Risk to financial viability associated with additional investment in nurse/midwifery staffing. Inadequate numbers of staff available to deliver services<br>**Impact:** Potential risk to patient safety and experience; risk to continuity of service rating; potential breach of CQC licence conditions<br>**Ulysses Ref: 1731.** | 146<br>1709<br>1863<br>1953 | Putting People First Strategy | DONM (GACA) | **5x4 =20** | **5x4 =20** | •Staffing Policies<br>•Escalation Policies<br>•Daily Monitoring Activity and Acuity<br>•Incident Reporting Policy and Process<br>•Bank<br>•Sickness and Absence Policy<br>•Health and Well Being Policy<br>•Unify returns<br>•Monitoring Performance Data<br>• Fill rates | •Annual Staffing Review<br>• Staff Survey & Pulse Survey<br>•KPI's<br>•Patient Survey<br>•Claims Litigation Incident PALS Report<br>• Monthly performance data (sickness)<br>•Nursing and Midwifery Board Minutes 08-04-14, (PPF Committee, 20-06-14, item 14/15/27)<br>• Leadership Programme Proposal (PPF Committee, 20-06-14, item 14/15/16)<br>• Evidence on NHS Choices<br>• CQC inspection report; overall rating for Trust Good | Yes | • Dashboard to be produced and tabled at GACA each month- to include current staffing levels, sickness, maternity, emerging risk and areas of concern.<br>• Staff feed back from Staff survey & Pulse Survey to be considered at PPF, | December, 2016 |
| **1b)** To comply with national standards for the safeguarding of children and adults<br>**Risk:** Failure to ensure effective arrangements with partners to safeguard vulnerable adults and children<br>**Cause:** Lack of direction and control , systems and processes<br>**Effect:** Potential failure to prevent harm; damage to Trust reputation<br>**Impact:** May result in avoidable harm; may result in regulatory action; financial penalty; prosecution .<br>**Ulysses Ref: 1732** | 1895 | Quality Strategy<br><br>Safeguarding Strategy (draft) | DONM (GACA) | **5x3 =15** | **5x3 =15** | •Safeguarding Strategy<br>•Policy<br>•Mandatory Training<br>• KPI's<br>• Partnership/Networking arrangements<br>• Safeguarding Board<br>• Further interim support identified | •Peer review & associated action plan<br>• Audit (associated with Regulation 11)<br>• Contractual KPI's<br>• Annual Safeguarding Report.<br>• External Safeguarding Review report September 2014 and July 2015 | Yes | •Safeguarding dashboard to be tabled to GACA each meeting to highlight progress against key recommendations and risks | December, 2016 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **1c)** To consider and appropriately respond to NICE guidance**Risk:** Failure to comply may result in adverse public reaction, additional cost pressure or resources. Contractual obligation being compromised. **Cause:** Lack of robust, efficient and effective management system for decision Effect: Non-compliance or appropriate administration**Impact:** Contractual failure, loss of revenue or service, breaches of safety and adverse public reaction (complaint).<br>**Ulysses Ref: 1733.** | 1597 | Quality StrategySafeguarding Strategy (draft) | MD (GACA) | **4X3 =12** | **4X3 =12** | • NICE guidance and clinical audit managed by Head of Dept.• Software generates compliance reports• Best Practice Policy• Reports to Clinical Governance Committee | •New External NICE Guidance (June, 2014), (Clinical Governance Committee, 13-06-2014, Item 14/15/83 ... 11-07-2014, Item 14/15/117 … 12 --09-2014, Item, 14/15/133)• Communication-LOTW | Yes | • Quarterly update to GACA-1. NICE guidance in last 1/4. 2. Compliance performance. 3. Non-Compliance rationale and risk. | December, 2016 |
| **1d)** To ensure lessons are learnt shared, and appropriate change enacted from the reporting and investigation of incidents locally and across the wider NHS Community.<br>**Risk:** Risk of repeat and costly events, regulatory action, service interruption, poor staff and patient experience<br>**Cause**: Poor system and training for reporting, recording, and investigating incidents<br>**Effect:** Compromised safety and learning outcomes<br>**Impact:** Regulatory action, increased cost, poor quality outcomes.<br>**Ulysses Ref: 1734** | 154<br>902<br>1707<br>1597 | Quality Strategy<br><br>Risk Management Strategy | DONM (GACA) | **4X4 =16** | **4X3 =12** | •Clear Policies(incident and SUI) • 10 yr. look back<br>•Mandatory Training<br>•RCA training<br>•Data Base recording and reporting | NRLS<br>•Performance Reports to GACA<br>• Complaints, Litigation, Incidents & PALS (CLIP) Report. (GACA 28-08-2014, Item,14/15/68)<br>•Serious Untoward Incident Report. (GACA 28-08-2014, Item,14/15/69)<br>• RCA training delivered September 2015<br>• NW Quality and Safety Forum member<br>• Quarterly SEE report | Yes | • Gap analysis of current themes. • Evidence/ Assurance that there are no un-escalated incidents.<br>•Formal process for review/assurance to be undertaken by clinical audit | December, 2016 |
| **1f)** To ensure the Trust has a robust business continuity plan that is understood and operational**Risk:** Failure to ensure the business continuity of the Trust **Cause:** Utilities, or Staff conditions creating major business interruption**Effect:** Limited service provision**Impact:** Compromised safety of service, financial loss.<br>**Ulysses Ref: 1736.** | 1571 | Business Continuity Plan | ADOps (GACA) | **5x4 =20** | **5x2 =10** | • Business Continuity Plan•Major Incident Plan• MRF Recovery Plan• Guidance early warning weather Report• Partnership/Local Authority/ Stakeholder working• Fuel Plan• Staff skills register• HPA plan | • Weather precautions (gritting)• Emergency Generator (monthly testing)• Drought/Flood plans ( external agencies)• Flu/Pandemic plans• Emergency exercise with Partners | None | | |

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| **1g)** Transportation of adults and neonates across the critical care network<br>**Risk:** Patient safety compromised by inadequate arrangements, pathways, protocols, systems and equipment required for the safe transportation of 'critical care' patients<br>**Cause:** Patients in 'critical care' require treatment outside the scope and expertise available at LWH<br>Effect: Vulnerable patients potentially exposed to journey hazards<br>**Impact:** Patient safety and experience could be compromised.<br>**Ulysses Ref: 1737.** | | Risk Management Strategy<br><br>Putting People First Strategy | ADOps (GACA) | **5x4 =20** | **5x2 =10** | Transportation critical care neonates:<br>• Specialised cots for transport<br>• Dedicated specialised trained staff<br>•Policy and procedure for transportation<br>•Cot Bureau - patient allocated specific cot<br><br>Transportation of Adults - critical care:<br>•Critical care network standards<br>•Dedicated trained staff<br>•Transport Policy<br>•Education training/support from networks<br>•Escalation Policy<br>•External KPI's | •Compliance with CRG specification NNTS<br>•External KPI's- reported to NNW and CMNN | Yes | • Seek patient's and clinician's feedback on the handling of transfers | January, 2017 |
| **1h)** Maintaining appropriate Regulatory Registration and Compliance<br>**Risk:** Insufficient robust processes and management systems that provide regulatory compliance performance and assurance.<br>**Cause**: Failure to provide evidence and assurance to regulatory agencies<br>**Effect:** Enforcement action, prosecution, financial penalties, image and reputational damage<br>**Impact:** loss of commissioners/patient confidence in provision of services.<br>**Ulysses Ref: 1739.** | | Business Continuity Plan<br>Risk Management Strategy<br>Putting People First Strategy<br>Quality Strategy | DONM (GACA) | **5x4 =20** | **5x2 =10** | • Monitor meetings<br>• CQC engagement meetings<br>• CQC registration updated to include detention of persons under Mental Health Act. | • CQC inspection report 2015; overall rating good. No restrictions placed on the Trust<br>• Internal inspection conducted in June 2016 to update regulatory knowledge | Yes | Inspection in December 2016 to include Exec, Non-Exec and external input | December, 2016 |
| **i)** To develop and support a comprehensive Clinical Audit provision<br>**Risk:** Failure to meet Statutory and Mandatory requirements, CPD for Clinicians<br>**Cause:** Lack of robust planning and monitoring, training and support<br>**Effect:** Breach of Statutory targets, failure of Trust to learn from clinical audit results<br>**Impact**: Potential action by CQC, image and reputation damage.<br>**Ulysses Ref: 1738.** | | Risk Management Strategy | MD (GACA) | **4x3 =12** | **3x3 =9** | •Forward Plan• Annual Report•Audits prioritised: Statutory, Mandatory and CPD• Performance KPI's | • Clinical Audit Forward Plan 2014/14- *What are the Trust's plans for clinical audit*? (GACAC 14-06-2014, Item, 14/15/44)•Research and Development Annual Report 2013/14- *What were the issues and achievements during the year*? (GACAC 14-06-2014, Item, 14/15/41)•Internal Audit (Baker Tilly) | Yes | • No evidence/assurances re-outcomes from clinical audit • Evidence required to show 'learning' from clinical audit | December, 2016 |

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| **1j)** Lack of robust systems and processes for the direction and control of Pharmacy and Medicine Management<br>**Risk**: Failure to maintain, update or review policy and guidance in a timely fashion<br>**Cause:** Staff shortages and change in leadership and arrangement with partner organisation<br>**Effect:** Significant amount of policy and guidance is past review date<br>**Impact**: Potential for safety to be compromised, staff not following best practice.<br>**Ulysses Ref: 1740.** | | Risk Management Strategy | ADOps (GACA) | **4x3 =12** | **4x3 =12** | • Training<br>• CPD<br>• Appraisal<br>• Medicines Management Committee | • Medicines Management Report -CQG Comm | Yes | | |
| **1k)** Isolated Site of LWH<br>**Risk:** Location, size, layout and current services do not provide for sustainable integrated care package for quality service provision.<br>**Cause:** Patient, Public and stakeholders expectations and the financial cost of maintaining current facilities is not sustainable<br>**Effect:** The Trust's image and reputation is damaged. Our service offer is less attractive to commissioners<br>**Impact**: Loss of Business and revenue, loss of confidence in the Trust's ability to meet the needs of patients<br>**Ulysses Ref: 1809.** | | Risk Management Strategy | DONM (~~FPBD~~) (GACA) | **5x4 =20** | **5x4 =20** | •Future Generation Project established<br>• Links to Stakeholders & Commissioners<br>• Project Board / Plans<br>• Monitoring of related care & service delivery issues via CGC and GACA. | • Board Papers / Updates Jan2014/ January 2015<br>• Project mandate<br>• Bi-monthly reports to Exec Committee.<br>. | None | | |

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| **1l)** Patient Experience for Transferred Women<br>**Risk:** Women are transferred out of Liverpool Women's for delivery elsewhere<br>**Cause:** Cot closures, failure of the system to limit post natal transfers in, an increase in the birth rate at LWH, an increase in the number of babies born at extremely preterm gestations and a reduced mortality rate for babies born at those gestations.<br>**Effect:** Women with babies likely to need admission to a Neonatal Unit because of either prematurity or congenital malformation are transferred out as there is no capacity to deliver this at Liverpool Women's due to reduced availability of neonatal cots.<br>**Impact:** Poor patient experience for transferred women, continued growth of the maternity service will not be possible without an expansion of neonatal capacity.<br>**Ulysses Ref: 1936.** | | Risk Management Strategy | ADOps (GACA) | **5x3 =15** | **4x3 =12** | • Raised with NHS England (increased funding for 48 cots)• Amended escalation policy re: out of area babies• Twice daily staffing and capacity reviews to Exec Team• Working with Neonatal network to preserve ITU cots for the sickest babies• Network Cot repatriation Policy in development• Daily Maternal & Neonatal review meetings | • Status Escalation Policy• Letters of escalation to NHS England• Network correspondence• Neonatal network Steering Group meetings• Meetings with NHS England• Incident reports of transfers• Log of transfers and outcomes | Yes | Respond to funding decision from NHS England | November, 2016 |

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| **1n)** Neonatal Estate**Risk:** Inability to safely meet the needs and demands of a changing neonatal service within the confines of the current environment and staffing establishment.<br>**Cause:** Increased intensity, rising demand and over occupancy of Neonatal Unit<br>**Effect:** Shortfall in staffing levels and skill mix to meet British Association of Perinatal Medicine (BAPM) standards, Inability to cohort colonised babies which is good practise without impacting on overall capacity within the unit, Environment does not meet the current requirement for a new unit (Health Building Note 09-03 Neonatal Units DOH 2013) leading to babies being nursed too close together and increasing risk of hospital acquired infection (HAI), lack of sufficient storage facilities for essential high cost equipment which is currently stored on main corridor increasing risk of damage , tampering and infection risk.<br>**Impact**: Moderate to severe harm to patients.<br>**Ulysses Ref: 1928** | | Risk Management Strategy | ADOps (~~FPBD~~) (GACA) | **4x4 =16** | **4x4 =16** | • Raised with NHS England (increased funding for 48 cots)• Amended escalation policy re: out of area babies• Twice daily staffing and capacity reviews to Exec Team• Working with Neonatal network to preserve ITU cots for the sickest babies• Network Cot repatriation Policy in development• Daily Maternal & Neonatal review meetings | • Status Escalation Policy• Letters of escalation to NHS England• Network correspondence• Neonatal network Steering Group meetings• Meetings with NHS England• Incident reports of transfers• Log of transfers and outcomes | Yes | Respond to funding decision from NHS England | November, 2016 |
| **1o)** Junior Doctors Shortage on Neonatal Transport<br>**Risk:** Inability to provide a Neonatal Transport service<br>**Cause:** Shortage of junior doctors, skills gaps within junior doctor workforce<br>**Effect:** Gaps in the Neonatal Transport Team rota, inability to provide a neonatal transport service<br>**Impact**: Failure to transfer seriously ill patients, moderate to severe harm to patients.<br>**Ulysses Ref: TBC** | | Risk Management Strategy | ADOps (GACA) | **4x4 =16** | **4x4 =16** | • Training for ANNPs<br>• Assessments of junior doctors against competency framework<br>• Upskilling of existing ST4s<br>• Collaboration on business plan to NHS England for North-West wide solution<br>• Working with Manchester and NHS England on interim plan | • Letters of escalation to NHS England<br>• Correspondence with Manchester<br>• Training records for ANNPs and ST4s<br>• Meetings with NHS England | Yes | Business case submission and decision from NHS England | March, 2017 |

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| | **2. To participate in high quality research and to deliver the most effective outcomes**<br><br>**Risk Appetite - Low** | | | | **Initial** | **Current** | | | | | |
| 2 | **a)** Research adds value, and enhances services and reputation of the Trust<br>**Risk:** Research is not linked to strategic aims<br>**Cause:** Research work plan potentially insular and not connected to quality improvement of service provision<br>**Effect:** Research fails to contribute to the work of LWH<br>**Impact**: The cost of research function fails to yield measurable effective outcomes.<br>**Ulysses Ref: 1741.** | | Risk Management Strategy | MD (GACA) | **4x3 =12** | **3x3= 9** | • Regular reports to Clinical Governance Committee | • R&D Governance Report CGC Nov 2014<br>• BT R+D Internal Audit Report | None | | |

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| | **3. To deliver the best possible experience for patients and staff**<br><br>**Risk Appetite - Low** | | | | **Initial** | **Current** | | | | | |
| 3 | **a)** To meet and where possible exceed patient expectations.<br>**Risk:** Failure to effectively engage and learn from patient, internal and external stakeholders to inform service development, corporate aims and annual plan**.**<br>**Cause:** Inadequate system & processes and structure; capacity and capability.<br>**Effect:** Failure to learn & improve the quality of service and experience.<br>**Impact**: Poor quality services leading to loss of income/activity; reputational damage; patient harm; turnover.<br>**Ulysses Ref: 1742.** | | Putting People First Strategy<br><br>Quality Strategy<br><br>Membership Strategy | DNM (GACA) | **4x4 =16** | **4x2= 8** | • Family and Friends Report<br>• Pt Stories to Board • Healthwatch /Stakeholders engagement<br>• Complaints and Compliments Report | •Patient & Staff Surveys• CLIP Report• Pt Stories to Board • Healthwatch /Stakeholders engagement<br>• Annual Complaints Report<br>• SI Report<br>• Performance Monitoring<br>• Nursing & Midwifery Indicators<br>• Compassionate Conversation- (PPFC, 20-06-2014, Item 14/15/14)<br>• Equality and Human Rights Committee minutes - (PPFC, 20-06-2014, Item 14/15/26)<br>• Family & Friends Tests<br>• Safety Thermometer<br>• Patient Engagement Strategy<br>• CQC inspection report; rating good for experience | None | | |

**Strategic Aim-** 4: To develop a well led, capable, motivated and entrepreneurial workforce

**Risk Target / Risk Appetite -** Moderate

| Risk Description | ID of Sub-Risks | Enablers | Exec Lead (Responsible Committee) | Risk Level | | Key Controls/Mitigation Action | Assurance/Evidence | Gaps in Control/ Assurance Level? | Action | Date for Completion |
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| | | | | Initial | Current | | | | | |
| **4a)** A competent and capable workforce: To support workers to deliver safe care by ensuring that all staff are clear about their role, objectives and performance, and have the opportunity to have their competencies and knowledge regularly updated<br>**Risk**: Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have staff with the capability and capacity to deliver the best care<br>**Cause**: Lack of time, inefficient processes or insufficient prioritisation by managers.<br>**Effect**: Employees not competent or equipped to ensure patient safety and maintenance of the organisational reputation<br>**Impact**: May result in unsafe care to patients, insufficient improvements in quality and breach of CQC conditions of registration resulting in regulatory action.<br>**Ulysses Ref: 1743.** | 1707<br>1704<br>1690<br>1445 | Putting People First Strategy | DWM (PPF) | **5x2 =10** | **5x2= 10** | •Clear Policies<br>•Metrics(KPI's)<br>• Performance Monitoring<br>•Training Regime<br>•Local OLM reports<br>• Induction<br>•All Staff aware of role and accountabilities | •Monthly Performance Report (Ops Board/Board of Directors)<br>• Internal audit report (PPF and Audit Committee)<br>• Annual Staff Survey (PPF Committee 20-06-14, item 14/15/10)<br>• Health and Well Being Strategy (PPF Committee 20-06-14, item 14/15/11)<br>•Education Governance Committee minutes (PPF Committee 20-06-14, item 14/15/24) | Yes | Deep dive into service 'Right person/ right place / right time tested at Putting People FirstPPF Committee agreed that an in-depth review of Mandatory Training be undertaken in order to provide assurance following concerns re: lack of assurance from KPI report and reported to PPF at next meeting | |

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| **4b)** An engaged, motivated and effective workforce: To deliver the Trust's vision of being a leading provider of healthcare to women, babies and their families through a highly engaged, motivated and effective workforce<br>**Risk:** staff are not engaged, motivated and aligned to the vision and values of the Trust resulting in poor patient experience and health outcomes , poor reputation and impact on the Trust's ability to recruit and retain the best.<br>**Cause**: Lack of time, inefficient processes or insufficient priority assigned by management.<br>**Effect:** Trust fails to become the provider and employer of choice for patient, commissioners, and employee**s**<br>**Impact:** impact on Trust's ability to recruit and retain the best, and on the Trust's ability to achieve its strategic vision.<br>**Ulysses Ref: 1744.** | 1444<br>1445 | Putting People First Strategy | DWM (PPF) | **4x4 =16** | **4x2= 8** | • Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff<br>• Consultant appraisal linked to Revalidation process<br>• Managers clear about their responsibility to undertake annual appraisals with their team<br>• Pay progression linked to appraisal and mandatory training compliance.<br>• Appraisal guides available for Managers and employees<br>• Monthly reporting at Departmental/ Divisional and organisation wide level via Performance Report.<br>• Targeted intervention for areas identified as under-=performing<br>• Training programme available for managers<br>• All new starters complete mandatory training Inc. PDR training as part of corporate induction ensuring awareness of their responsibilities.<br>• Consultant revalidation requires mandatory training compliance<br>• Extensive mandatory training programme available via classes, online resources and study days<br>• Monitored at Education Governance Committee. | • CQC visit of April 2014 identified improvement in appraisal rates and recorded compliance with 'Supporting workers' - outcome 14.<br>• Pay progression policy recently implemented. Impact of policy will not be evaluated until 2015-16<br>• Increase in managers attending training programme<br>• Annual internal audit of policy by Trust's audit partners. Due to report Q3 2014-15<br>• Review by Trust's audit partners showed that system and processes used are effective if applied consistently across the Trust.<br>•Compliance with GMC Revalidation requirements<br>• Monthly performance report for June 2014 identifies organisational compliance at 84% for mandatory training. Areas identified requiring intervention Imaging & Maternity. | Yes | New leadership programme designed around the Trust values and behaviours framework<br><br>Complete OLM project in accordance with agreed timescales<br><br>Expedite roll out and promotion of e-learning<br><br>Evaluate impact of pay progression policy.<br><br>Develop project plan to implement Self Service | |

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| **4c)** To maintain delivery of clinical services<br>**Risk:** Insufficient Junior Doctors or disruption to care/the environment in which care is given resulting in harm to patients, damage to organisational reputation and impact upon income and achievement of access targets.<br>**Cause:** Industrial action by Junior Doctors<br>**Effect:** Trust is unable to deliver clinical services.<br>**Impact:** Damage to reputation, income and access targets.<br>**Ulysses Ref: 1909.** | 146<br>1709<br>1635 | Putting People First Strategy | DWM (PPF) | **4x3 =12** | **4x3= 12** | • Pro-formas sent to CD's to assess impact of industrial action on clinical activity and to make contingency arrangements.<br>• Pro-forma sent to junior and Trust grade doctors re "intentions".<br>• Lessons learnt from industrial action taken previously<br>• All planned industrial action is now completed (awaiting results of national ballot on 7 July | • All CD's and Heads of Service have plans in place (SMT 6/1/16)<br>Pro-forma re service provision sent to all CD's 5/1/16 for completion.<br>Mitigation Actions for Junior Doctor strike 12-13th February effective (no directly related incidents reported in that period) | Yes | De-briefing to review and note any lessons to be learned from previous action | |

**Strategic Aim & Reference –** 5: To be ambitious and efficient and make the best use of available resources

**Risk Target / Risk Appetite** - Significant

| Risk Description | ID of Sub-Risks | Enablers | Exec Lead (Responsible Committee) | Risk Level | | Key Controls/Mitigation Action | Assurance/Evidence | Gaps in Control/ Assurance Level? | Action | Date for Completion |
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| | | | | Initial | Current | | | | | |
| **5ai)** To deliver the financial plan beyond 2016/17<br>**Risk:** The Trust does not have a financially sustainable plan in 2016/17<br>**Cause:** Tariff insufficiency, commissioner intentions, CNST premiums and liabilities and inability to identify further significant CIPs<br>**Effect:** Requirement for Distressed Financing, Breach of Licence Conditions<br>**Impact:** Regulatory Intervention<br>**Ulysses Ref: 1663** | 1663 | Risk Management Strategy | DOF (FPBD) | **5x5 =25** | **5x5 =25** | • Zero based budget methodology adopted<br>• Voluntary turnaround process adopted to identify robust CIP schemes<br>• FPBD & Board approval of budgets<br>• Sign off of budgets by accountable officers<br>• Monthly reporting to all budget holders with variance analysis<br>• Monthly reporting to FPBD & Trust Board<br>• Monthly reporting to Monitor | • 2016/17 plan approved by Trust Board in April<br>• Performance & Finance Report presented monthly to FPBD<br>• Finance & CIP achievement reported monthly to FPBD, Executive Team and Operational Board<br>• Monthly budget holder meetings<br>• Monthly reports to monitor<br>• Internal audit review of budgetary controls | None | Ongoing review of position | Mar-17 |

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| **5aii)** To deliver the financial plan beyond 2016/17<br>**Risk:** The Trust does not deliver the 2016/17 financial plan and control total<br>**Cause:** Lack of operational grip and financial controls<br>**Effect: N**on-delivery of the financial plan and reduction in available cash<br>**Impact:** Further regulatory intervention and special measures<br>**Ulysses Ref: 1663** | 1381 | Risk Management Strategy | DOF (FPBD) | **5x3 =15** | **5x3 =15** | • Zero based budget methodology adopted<br>• Voluntary turnaround process adopted to identify robust CIP schemes<br>• FPBD & Board approval of budgets<br>• Sign off of budgets by accountable officers<br>• Monthly reporting to all budget holders with variance analysis<br>• Monthly reporting to FPBD & Trust Board<br>•Monthly reporting to Monitor | • 2016/17 plan approved by Trust Board in April<br>• Performance & Finance Report presented monthly to FPBD<br>• Finance & CIP achievement reported monthly to FPBD, Executive Team and Operational Board<br>• Monthly budget holder meetings<br>• Monthly reports to monitor<br>• Internal audit review of budgetary controls | None | Ongoing review of position | Mar-17 |
| **5b)** To deliver long term financial sustainability<br>**Risk:** The Trust is not financially sustainable beyond 2016/17<br>**Cause:** Tariff insufficiency, commissioner intentions, CNST premiums and liabilities, non delivery of CIP<br>**Effect:** Lack of financial stability and ability to fund services, insolvency and Trust unable to deliver services<br>**Impact:** Invocation of Monitor sanctions-special measures.<br>**Ulysses Ref: 1986.** | 1663 | Risk Management Strategy | DOF (FPBD) | **5x5 =25** | **5x5 =25** | • 5 year financial model produced giving early indication of issues<br>• Advisors with relevant experience (PWC) engaged early to review strategic options<br>• Early and continuing dialogue with Monitor<br>• Active engagement with CCG's through the Healthy Liverpool Programme<br>• Final Business Case to Trust Board in Dec 15<br>• Clinical engagement through regular reporting to Trust Management Group | • 5yr plan presented to Board, June, 2014<br>• Business Case, November, 2014 | Yes | Finalisation of shortlist of options and development of preferred option Dec 2016 Further discussion with NHSLA following outcome of consultation exercise Sept 2016 | Mar-17 |
| **5c) De-escalated** | | | | | | | | | | |
| **5d)** Fail to achieve benefits from the IT Strategy<br>**Risk:** Failure to successfully deliver the IM&T Strategy<br>**Cause:** Poor programme management controls<br>**Effect:** Programme running over budget, out of scope, late or non delivery of stated benefits realisation<br>**Impact:** Trust being non compliant with national initiatives, data collection requirements or financial compliance.<br>**Ulysses Ref: 1750.** | 902 | IM&T Strategy | DOF (FPBD) | **4x4 =16** | **4x4 =16** | • IM&T Business case<br>• Capital Reporting Plan<br>• Project Management Office<br>• Project Plan established<br>• Programme Board in place and meeting regularly<br>• Regular reports to FPBD<br>• Robust business continuity plan in place<br>• Supplier contracts<br>• Replicated data centres<br>• Disaster recovery plans<br>• System Training<br>• Doing IT Right Strategy<br>• IM&T policies / Data Protection Policy / Data Quality Policy<br>• Structured change control in line with ITIL | • IM&T business case approved (TB)<br>• Programme Board in place, minutes available<br>• Quarterly FPBD reports | Yes | New Plan for EDMS and Bed Management to be formulated July 2016.<br>EPR business case to be implemented per project plan | Jul-16 |

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| 5e) To develop a sustainable Genomic Centre<br>**Risk:** Potential loss of service following re-commissioning of genetics nationally - unsuccessful tender service cost<br>**Cause**: Relatively small unit<br>**Effect**: Loss of service and financial contribution of £1.5m per-p.a.<br>**Impact**: Loss of genetics service through failure to engage appropriately in the future model of genetics service provision in Liverpool / North West .<br>**Ulysses Ref: 1749.** | | Risk Management Strategy | DOF (FPBD) | **4x4 =16** | **4x4 =16** | • External Engagement through the Liverpool Health Partners<br>• Genetics strategy group in place<br>• Significant engagement with NHS England through national lead<br>• Successful 100,000 genome bid<br>• Developed MOU to collaborate with LCL to meet service specification | • Successful submission of tender to NHS England 100,000 genome project<br>• MOU with LCL | Yes | • Tender date for genomic hub yet to be confirmed. To be kept under review | TBC by NHS Genomics |

## Appendix 3 – Full Corporate Risk Register Dashboard

| Dept | Risk ID | Domain | Description | Creation Date | Consequence/ Severity | Likelihood | Initial Score | Current Score | Responsible Committee | Risk Owner (& Exec Lead) | Progress / Escalation narrative |
|---|---|---|---|---|---|---|---|---|---|---|---|
| HR | 146 | HR/Organisational Development/ | Risk of inability to maintain safe medical rotas due to inadequate numbers of doctors in training allocated to the Trust with the potential risk to delivery of safe care | 05/02/2015 | 3 Moderate | 2 Unlikely | 12 | 6 | Putting People First | Susan Westbury (Michelle Turner) | HR feel this should remain as a corporate risk as it is a service wide issue across all the specialties and relates to medical staff. The responsibility and accountability for managing these staff is shared with the Clinical Directors and Ops Managers across the services and the Medical Director and HR.<br><br>On-going meetings with Consultant Education Leads, Rota managers and Heads of Operations re rota's and alternative working.<br>Engagement with medical director and links re 7 days service planning for medical workforce. |
| Governance | 1597 | Impact On The Safety Of Patient | Risk is to Patient harm due to inaccurate results due a lack of good Governance surrounding POCT. Resulting in incorrect treatment & management of patient care. There is the potential for litigation & damage to organisational reputation. | 04/09/2015 | 3 Moderate | 3 Possible | 16 | 9 | GACA | Chris McGhee (Andrew Loughney) | There are a considerable number of issues still surrounding POCT that have not been addressed by the provider. It has been assessed that this is still a considerable risk and needs to remain corporate. |

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| HR | 1709 | HR/Organisational Development/ | Insufficient consultant or senior medical cover.<br><br>Caused by high levels of sickness/absence/maternity leave; insufficient investment in or supply of senior medical staff; high vacancy factor; insufficient workforce planning or adjustment for case-mix; or insufficient supply of suitably qualified/experienced staff.<br><br>May result in an inadequate patient experience; a failure to protect patients or staff from serious harm; loss of stakeholder confidence; and/or a material breach of CQC conditions of registration | 15/08/2014 | 3 Moderate | 4 Likely | 6 | 12 | Putting People First | Michelle Turner | The responsibility and accountability for managing these staff is shared with the Clinical Directors and Ops Managers across the services and the Medical Director and HR.<br><br>Review of WFP for medical staff (juniors & consultant) being undertaken in conjunction with General Manager for Women's & Children's Service - 1/4ly updates<br><br>Risk score updated to a 12 at most recent review. |
| Information Team | 1836 | Impact On The Safety Of Patient | Risk of inaccurate reporting of clinical outcome data caused by incorrect data entry of clinical data into clinical systems or inaccurate clinical coding or dataset production resulting in outlier concerns. | 04/09/2015 | 3 Moderate | 3 Possible | 12 | 9 | GACA | Steve Chokr (Andrew Loughney) | Risk was added due to concerns around lack of ownership of data quality within the organisation. Continued concerns of lack of ownership of data quality within the organisation were escalated and discussed at IG Committee. Last review (January 2017) showed no changes to that position. |

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| Clinical Genetics | 1863 | Impact On The Safety Of Patient | There is an ongoing risk of patients needing to see a medic will continue to breach 18 weeks.<br>Within this there is a cohort of patients who maybe at risk of failure to get appropriate treatment or screening due to the delay in genetic assessment. This is due to 70% increase in referrals over the last 3 years with static staffing levels. A service redesign has been completed and 1000 new appointments created. This provided some relief however referral rates continue to increase and this capacity has been absorbed. | 05/10/2015 | 4 Major | 3 Possible | 12 | 12 | GACA | Lynn Greenhalgh (Andrew Loughney) | Currently clinical genetics is breaching 18 weeks for patients who need an appointment with some pushing 40 weeks. Risk originally escalated to Corporate Risk as a business case was submitted to the Ops Board who, although supportive, were unable to identify funding to allocate.<br><br>Business Case for new Consultant has now been accepted and approved by Exec Team & recruitment processes commenced. No change in risk level however and breaches are looked at by Genetics Management. Any cases that can be transferred from Medic Clinic to GC clinic whilst still maintaining appropriate care are being triaged appropriately.<br><br>NHS E agreed additional funding of service in light of demand – recruitment underway. Further business case related to 100K Genomes is still with NHSE for increased in base number of 2x Scientists, 1.5 GCs and 0.5 WTE Consultant. This business case is not expected to be reviewed until after April 2017<br><br>Risk owner changed to Medical Director (from DoWM) |

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| Safeguarding | 1895 | Impact On The Safety Of Patient | Risk: Lack of robust systems and processes to ensure the safeguarding of LWH patients.<br>Cause: Change in management, legislative requirements, lack of policy, training and governance.<br>Effect: Poor staff morale, inadequate organisational leadership, assurance and engagement.<br>Impact: Potential for patient safety to be compromised. | 03/06/2016 | 3 Moderate | 3 Possible | 12 | 9 | GACA | Amanda McDonough (Dianne Brown) | Originally escalated to Corporate Risk Register in reflection of prevailing national profile of Safeguarding issue. Hospital Safeguarding Board will discuss the potential de-escalation of this risk to the Service Risk Register following completion of actions (2 remain ongoing at latest review in December).<br><br>There is an overarching Safeguarding Risk included on BAF and this risk is more operational in support of it. |
| Maternity | 1953 | Impact On The Safety Of Patient | Insufficient junior doctor staffing levels may result in an inadequate patient experience; a failure to provide appropriate care during labour; a failure to protect patients or staff from serious harm<br>Caused by high levels of sickness/absence/maternity leave; insufficient investment in staffing; high vacancy factor; insufficient workforce planning; or insufficient supply qualified staff<br>Potential loss of stakeholder confidence; and/or a material breach of CQC conditions of registration | 21/03/2016 | 5 Catastrophic | 3 Possible | 15 | 15 | Putting People First | Devender Roberts (Andrew Loughney) | Escalated to Corporate Risk as recruitment issues involved are beyond the ability of service to resolve.<br><br>Risk review in November instigated O and G Workforce planning meeting for Jan 2017. Contingency plans are in place for junior doctor gaps. |

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| Finance | 1962 | Business Objectives/projects | Failure to implement Future Generations strategy.<br>Cause: Poor, ineffective or protracted change management in the CCG's implementation of the FG plan, conflicts between implementation of the Future Generations strategy and Healthy Liverpool programme.<br>Effect: Reduced staff morale, loss of staff confidence in and support of the project. Confusion amongst service users re provision, reputational damage to trust and brand, potential migration of service users to other providers and problems with staff recruitment and retention.<br>Impact: Project fails to meet clinical and quality standards and expectations of Monitor and NHSE | 17/03/2016 | 4 Major | 3 Possible | 12 | 12 | FPBD | Jenny Hannon (Vanessa Harris) | Reflects focus on CCG implementation in conjunction with Healthy Liverpool programme.<br><br>A review of this risk was due in October |
| Imaging | 1964 | Impact On The Safety Of Patient | Risk: Lack of a robust system to ensure that imaging results are reviewed and appropriate subsequent action taken.<br>Cause: No apparent formal agreement with partner Trust detailing responsibilities in relation to alerting medical staff to significant / unexpected results, nor robust process to ensure medical review.<br>Effect: Potential for missed diagnosis, lack of appropriate intervention, treatment and care resulting in severe harm or death of patient(s).<br>Impact: Realisation of avoidable serious incidents and claims, loss of reputation and regulatory sanctions. | 17/03/2016 | 4 Major | 4 Likely | 16 | 16 | GACA | Marianne Hamer (Andrew Loughney) | Identified through investigation of a serious incident.<br><br>Formal SLA with RLUH ongoing. Informal arrangements for reporting adult x-ray examinations by radiologists and notification of abnormal results in place.<br><br>Safety Senate & GACA are receiving regular updates on the ongoing work to manage risks regarding test results. |

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| Women's & Children's | 1966 | Impact On The Safety Of Patient | Risk of safety incidents occurring when undertaking invasive procedures due to safety standards for invasive procedures ( LocSSIPS and adapting NatSSIPS) not being in place / embedded throughout the organisation resulting in potential harm to patients, Never Events/ SUIs Safety incidents, reputational damage, none compliance with CQC standards and patient Safety Alert NHS/PSA/RE/2015/008 which is to be implemented by 14th September 2016 | 06/04/2016 | 4 Major | 3 Possible | 12 | 12 | GACA | Alan Clark (Andrew Loughney) | The Safe procedures working group is meeting monthly and progressing through the gap analysis. Some local development of safety checklists has progressed and an audit tool has been developed. There are still concerns regarding consultant engagement and these have been flagged to the MD<br><br>Risk Owner changed in January from Head of Nursing.<br><br>A review of this risk was due in October |
| Pharmacy | 1983 | Impact On The Safety Of Patient | Pharmacy practice unit provides one day a week IT support to the pharmacy department. Predominantly for report construction, maintenance and databases. This person is likely to retire in the near future. Risk of loss of business continuity, lack of information for decision making from meditech. | 07/07/2016 | 4 Moderate | 3 Possible | 16 | 12 | GACA | Paul Skipper (Jeff Johnston) | Escalated to Corporate Risk as person has now given notice of intention to retire. There will be a significant knowledge gap and urgent action is now required.<br><br>Risk score lowered in September as there was an ongoing review with IT to put in place named individual to oversee.<br><br>A review of this risk was due in December |

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| Gynaecology | 2018 | Impact On The Safety Of Patient | Risk: Inability to provide a good, safe and effective Gynaecology Emergency Service for patients.<br>Cause: Insufficient clinical and managerial overview and resource in Gynaecology Emergency Services to meet the increasing demands.<br>Effect: Lack of dedicated Clinical leadership resource, junior doctor rota gaps and deficits in junior doctor and nursing work force and expertise. Poor guideline management. Failure of A&E targets. Lack of responsiveness to the increasing gynaecology emergency activity demands and case complexity with insufficient supporting resource, including scan capacity.<br>Impact: Poor patient experience, potential untoward incidents, complaints and litigation, failure to meet regulatory requirements and reputation damage. | 14/10/2016 | 5 Catastrophic | 3 Possible | 10 | 15 | GACA | Chris McGhee (Andrew Loughney) | Nursing workforce review submitted and papers submitted to GACA. Requires business case development and oversight as a Corporate Risk.<br><br>Risk likelihood increased to reflect increase in sickness, turnover and incident reports generated re staffing shortages and inability to cover telephone line. Ward staff have also raised concerns regarding being redeployed into areas where they are unfamiliar with processes, access to Meditech screens, local induction, equipment competencies. Also potential need for redeployments from ward area as part of inpatient redesign and the SMT process for recruitment approval can leave vacancies unfilled for longer.<br><br>Risk owner updated in January |

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| Gynaecology | 2039 | Impact On The Safety Of Patient | Clinical Risk : Potential inability to provide oncology, emergency gynaecology or high risk obstetric services as a result of losing level 2 status within Cheshire and Merseyside Critical Care Network as a consequence of failure to comply with minimum requirements for a critical care practice educator to ensure critical care competencies are maintained by staff providing this care. | 04/10/2016 | 4 Major | 4 Likely | 16 | 16 | GACA | Chris McGhee (Andrew Loughney) | Escalated by Safety Senate in August 2016 following discussions regarding evaluation by the Critical Care Network.<br><br>Discussions with RLUBHT have taken place and they initially informed us that they did not have provision to provide Practice Educator Support. This has been escalated to Exec level and a further decision is awaited. Critical Care Network Informed.<br><br>Risk owner updated in January |
| Estates | 2044 | Business Objectives / projects | Loss Of Power: The Trust energy infrastructure was originally constructed using an external single point of supply by Scottish Power rather than a dual feed. In the event of an interruption we would only be able to supply approximately 40% of the Trusts energy. | 15/08/2016 | 5 Catastrophic | 2 Unlikely | 10 | 10 | FPBD | John Foley (Vanessa Harris) | Awaiting further update and review by incoming Head of Estates |