Meeting of the Board of Directors
HELD IN PUBLIC
Friday 7 October 2016 at Liverpool Women's Hospital at 1015 a.m.
Board Room

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard	BAF Risk
	Thank you to Staff				1015 15mins		
238	Apologies for absence & Declarations of interest	Receive apologies	Verbal	Chair		-	-
239	President of the Royal College of Obstetricians and Gynaecologists.		verbal	David Richmond	1030 20mins	-	-
240	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair	1050 10mins	R17 – Good Governance	-
241	Minutes of the previous meetings held on Friday 1 July 2016	Confirm as an accurate record the minutes of the previous meetings	Written	Chair		R17 – Good Governance	-
242	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	-
243	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1100 10mins	R17 – Good Governance	All
244	Chief Executive Report	Report key developments and announce items of significance not elsewhere	Written	Chief Executive	1110 10mins	R17 – Good Governance	All
245	Safeguarding Annual Report 2015/16	To receive and approve the Report	Written	Director of Nursing and Midwifery	1120 10mins	R13 - Safeguarding	1b&c
246	Director of infection Prevention and Control Report 2015/16	To receive and approve the Report	Written	Director of Nursing and		R12 – Safe Care	1n

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard	BAF Risk
				Midwifery			
247	PLACE Assessment 2016	To note the Trust's performance from the PLACE Assessment 2016	Written/ Presentation	Director of Nursing and Midwifery/ Patient Facilities Manager	1130 10mins	R12&15: Safe R9&10 Caring R14: Effective	3
BOARD ASSURANCE							
248	Chair's Report from the Finance Performance and Business Development Committee held on 26 September 2016	Receive assurance and any escalated risks	Written	Committee Chair	1140 20mins	R17 – Good Governance	5b-g
249	Chair's Report from the Governance and Clinical Assurance Committee held on 16 September 2016	Receive assurance and any escalated risks	Written	Committee Chair		R17 – Good Governance	1&3
250	Chair's Report from the Putting People First Committee held on 23 September 2016 and Annual Report 2015/16	Receive assurance and any escalated risks	Written	Committee Chair		R17 – Good Governance	4
TRUST PERFORMANCE							
251	Performance Report period 5, 2016/17	Review the latest Trust performance report and receive assurance	Written	Associate Director of Operations	1200 10mins	R12&18: Safe R17 – Good Governance	3a
252	Finance Report period 5, 2016/17	To note the current status of the Trusts financial position	Written	Director of Finance	1210 10mins	R17 – Good Governance	5
TRUST STRATEGY							
253	Future Generations Update	To brief the Board on progress and risks	Verbal	Chief Executive	1220 10mins	All	All

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard	BAF Risk
BOARD GOVERNANCE							
254	Corporate Risk Register	To review and note the current risks not being able to manage at a service level	Written	Director of Nursing and Midwifery	1240 15mins	R17 – Good Governance	All
255	Board Assurance Framework	To review and note the current risks not being able to manage at a service level	Written	Trust Secretary		R17 – Good Governance	All
256	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1255 5mins	R17 – Good Governance	All
HOUSEKEEPING							
257	Any other business	Consider any urgent items of other business	Verbal	Chair		-	-
258	Review of meeting	Review the effectiveness of the meeting (achievement of objectives/desired outcomes and management of time)	Verbal	Chair / all		-	-

Date, time and place of next meeting either Friday 4 November 2016

Meeting to end at 1300

1300-1315 15 mins	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

David Richmond
President of the Royal College of Obstetricians and Gynaecologists.

Meeting attendees' guidance, May 2013

Under the direction and guidance of the Chair, all members are responsible for ensuring that the meeting achieves its duties and runs effectively and smoothly.

Before the meeting

- Prepare for the meeting in good time by reviewing all reports
- Submit any reports scheduled for consideration at least 8 days before the meeting to the meeting administrator
- Ensure your apologies are sent if you are unable to attend and *arrange for a suitable deputy to attend in your absence
- Notify the Chair in advance of the meeting if you wish to raise a matter of any other business

*some members may send a nominated representative who is sufficiently senior and has the authority to make decisions. Refer to the terms of reference for the committee/subcommittee to check whether or not this is allowable

At the meeting

- Arrive in good time to set up your laptop/tablet for the paperless meeting
- Switch to silent mobile phone/blackberry
- Focus on the meeting at hand and not the next activity
- Actively and constructively participate in the discussions
- Think about what you want to say before you speak; explain your ideas clearly and concisely and summarise if necessary
- Make sure your contributions are relevant and appropriate
- Respect the contributions of other members of the group and do not speak across others
- Ensure you understand the decisions, actions, ideas and issues agreed and to whom responsibility for them is allocated
- Do not use the meeting to highlight issues that are not on the agenda that you have not briefed the chair as AoB prior to the meeting
- Re-group promptly after any breaks
- Take account of the Chair's health, safety and fire announcements (fire exits, fire alarm testing, etc)

Attendance

- Members are expected to attend at least 75% of all meetings held each year

After the meeting

- Follow up on actions as soon as practicably possible
- Inform colleagues appropriately of the issues discussed

Standards & Obligations

1. All documentation will be prepared using the standard Trust templates. A named person will oversee the administrative arrangements for each meeting
2. Agenda and reports will be issued 7 days before the meeting
3. An action schedule will be prepared and circulated to all members 5 days after the meeting
4. The draft minutes will be available at the next meeting
5. Chair and members are also responsible for the committee/ subcommittee's compliance with relevant legislation and Trust policies
6. It is essential that meetings are chaired with an open and engaging ethos, where challenge is respectful but welcomed
7. Where consensus on key decisions and actions cannot be reached this should be noted in the minutes, indicating clearly the positions of members agreeing and disagreeing – the minute should be sufficiently recorded for audit purposes should there need to be a requirement to review the minutes at any point in the future, thereby safeguarding organisational memory of key decisions
8. Committee members have a collective duty of candour to be open and honest both in their discussions and contributions and in proactively at the start of any meeting declaring any known or perceived conflicts of interest to the chair of the committee
9. Where a member of the committee perceives another member of the committee to have a conflict of interest, this should be discussed with the chair prior to the meeting
10. Where a member of the committee perceives that the chair of the committee has a conflict of interest this should be discussed with the Head of Governance and/or Trust Board Secretary
11. Where a member(s) of a committee has repeatedly raised a concern via AoB and subsequently as an agenda item, but without their concerns being adequately addressed the member(s) should give consideration to employing the Whistle Blowing Policy
12. Where a member(s) of a committee has exhausted all possible routes to resolve their concerns consideration should be given (which is included in the Whistle Blowing Policy) to contact the Senior Independent Director to discuss any high level residual concerns. Given the authority of the SID it would be inappropriate to escalate a non risk assessed issue or a risk assessed issue with a score of less than 15
13. Towards the end of the meeting, agendas should carry a standing item that requires members to collectively identify new risks to the organisation – it is the responsibility of the chair of the committee to ensure, follow agreement from the committee members, these risks are documented on the relevant risk register and scored appropriately

Speak well of NHS services and the organisation you work for and speak up when you have Concerns

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Board Agenda item

Board of Directors

Minutes of the meeting of the Board of Directors
held public on Friday 2 September 2016 at 1000 hrs
in the Boardroom, Liverpool Women's Hospital, Crown Street

PRESENT	
Mr Robert Clarke	Chair
Mr Ian Haythornthwaite	Non-Executive Director/Vice Chair
Mr Phil Huggon	Non-Executive Director
Mr Tony Okotie	Non-Executive Director/SID
Mr Ian Knight	Non-Executive Director
Mr David Astley	Non-Executive Director
Dr Susan Milner	Non-Executive Director
Ms Jo Moore	Non-Executive Director (sections 166-177 incl.)
Mrs Kathryn Thomson	Chief Executive
Mrs Vanessa Harris	Director of Finance
Mrs Michelle Turner	Director of Workforce & Marketing
Dr Andrew Loughney	Medical Director
Mrs Dianne Brown	Director of Nursing & Midwifery
IN ATTENDANCE	
Mr Colin Reid	Trust Secretary
APOLOGIES	
Mr Jeff Johnston	Associate Director of Operations

Thank You
Before the meeting opened formally the Board expressed its thanks to the Hewitt Fertility Team represented by Andrew Drakeley, Clinical Director and Karen Schnauffer Head of Laboratories & HFEA Person Responsible, for the recent and very successful HFEA inspection and great clinical services it provides.

204 **Apologies** – as above

Welcome: The Chair welcomed members of the public who were observing the Board meeting and advised they would have opportunity to ask questions of the Directors after the meeting.

Declaration of Interests – None

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

206 Patient Story – Elizabeth Ivy Copeland

The Chief Executive introduced Beth Copeland and Mr and Mrs Copeland. She explained that Beth was born at the hospital and she has kept in touch with her through Beth's continued development. Beth has been an inspiration to many people as she faced her many challenges.

Beth's mum provided the Board with a short inspirational presentation on Beth's journey taking into account those challenges that she and her husband faced when being diagnosed and the incredible support she had received from the Hospital. Beth's mum advised that they had longed for a baby and when she became pregnant there was so much joy, until as she put it there was a black cloud on the horizon when Beth was diagnosed with fetal defect at a local hospital. Beth's mum explained that there was very little support from the provider at the time and she had asked to be referred to Liverpool Women's Fetal Medicine Unit. The support she received from the LWH and in particular Professor Zarko Alfirevic was incredible and who provided a different prognosis. Beth was born at the hospital and was transferred to Alder Hey.

Beth's mum went on to explain Beth's journey in terms of her resilience when having to have treatment over the years and as an ambassador for Go Folic, her work with the Charity J-U-M-P (a NW charity that supports children across the North West who have life limiting health conditions) as flower girl for mobility and her presentation of a bouquet of flowers to the Queen. Beth's mum advised that Beth had done some amazing things and would continue to do so as she starts a new adventure in High School and explained that this may not have been the case if she hadn't had come to the Hospital and seen Professor Alfirevic and had the fantastic support from all the staff.

The Chair thanked the family for taking time out to come to the Trust so that the Board could meet a truly amazing and inspirational young lady.

207 Minutes of previous meeting held on Friday 1 July 2016

The minutes of the meeting held on 1 July 2016 were approved.

208 Matters arising and action log.

The Board noted that all actions were either complete or on the agenda with exception of the report back from the Charity Funds Committee workshop. It was explained that the output from the workshop was being developed and would be discussed at the next Charity Funds Committee in developing the strategy going forward. It was agreed that the next Chair's report from the Charity Funds Committee would include an update on the strategy.

209 Chair's Report

The Chair provided a brief verbal report:

Council of Governors Meeting: The Chair reported on the last Council of Governors meeting at which there was very good discussion and challenges on the matter presented to the meeting. He explained that as agreed there was reduction in presentations by power point and more real life assurances were given during the meeting, referring in particular to the Inpatient Survey outcomes agenda item when Matrons from three of the services provided by the Trust provided an update on the services and issues faced.

Governor Elections: The Board noted that the four Governor constituencies had been filled.

Genetics Team: The Chair reported that he had opportunity to sit in on a number of cases in outpatients' clinics and was struck by the services the Trust provided to whole families, referring to the mapping of genomes within families. He was looking forward to hearing more under the 100,000 Genomes presentation later in the meeting.

The Board noted the Chair's update report.

210 **Chief Executive's report**

The Chief Executive presented her report, in particular referring to Liverpool being chosen as the Royal College of Physicians Northern Headquarters and the CQC mock inspections that were being organised.

The Chief Executive referred to the Junior Doctors Contract and reported that the BMA had announced a succession of strikes, the first had been set for 12-16 September 2016. As with previous strike action, planning arrangements were being put in place to keep disruption to a minimum for the Trust's service users. Phil Huggon asked that a paper is presented to the Board following the strike action setting out any issues identified during the strike and what the cost implications were.

ACTION 210: the Associate Director of Operations to provide a briefing note on the impact of the impending junior doctors strike (September 2016).

211 **100,000 Genomes Project**

Angela Douglas MBE, Clinical Programme Director gave a presentation on the 100,000 Genomes Project. She explained the background behind the project which had been announced by the Prime Minister in December 2012 and focused on sequencing the whole genome of patients with rare inherited diseases and certain cancers with Genomics England co-ordinating the work. In December 2014 NHS England established 13 NHS Genomic Medicine Centres (GMC) to coordinate activity across populations, working to common protocols and specification ensuring comparability and quality of science and data. The Trust was appointed the lead GMC for the North West Coast and includes 12 local delivery partners across the region.

The Clinical Programme Director went on to explain how the project worked, how each elements of the project fitted together, the key targets and how the project was currently doing and provided examples of how genomic diagnosis would help shape clinical management and treatments, which would improve outcomes for patients and reduce variations in clinical care.

In response to a question on delivering the target samples by the local delivery partners, the Clinical Programme Director advised that pressure from the Chief Executive Office to the CEO's of the delivery partners was important to support the project and be held to account. She further advised that due to the specific nature of the sample disease it had been difficult to recruit patients to participate. With regards to the costs of the project it was reported that was a potential small financial risk to the Trust should the local delivery partners not deliver the number of patients as the North West Coast GMC lead.

The Chair thanked the Clinical Programme Director and the Genomics Team for attending the Board and provide a very interesting presentation on the project.

212 **Emergency Preparedness - self-assessment of compliance with the core standards**

The Director of Nursing and Midwifery presented the Emergency Preparedness, Resilience & Response (EPRR) annual report 2016 and the statement of compliance that was required to be approved by the Board. She reported that there were a number of core standards that were not fully compliant (partial compliant) and mitigating actions were being put in place to address this. It was noted that the Trust had previously been fully compliant and a number of questions was raised as to why this year's assurance report provided only partial compliance.

It was agreed that the Director of Nursing and Midwifery/Associate Director of Operations to bring a report back to the Board in April 2017 that on addressing those areas of partial compliance to the core standards. It was further agreed that the Governance and Clinical Assurance Committee at its meeting on 16 September 2016 consider the following questions posed by the Board:

1. *What were the internal work plan and live audits, how were these tested and how do they provide assurance.*
2. *Why was the Trust not fully complaint when it had been in previous years.*
3. *Was there a requirement for Executive Director's to have on call training, how and when will this happen and how was this tested.*
4. *Does the non-compliance increase the risk in terms of service delivery and safety and if so was there a need for the risk to be escalated to the Board Assurance Framework.*

The Board noted the timeframes for the delivery of the 2016-17 EPRR assurance process; supported the actions required and approved the statement of compliance and the action plan to improve compliance.

ACTION 212: Associate Director of Operations to bring a report back to the Board in April 2017 that on addressing those areas of partial compliance to the core standards. The Governance and Clinical Assurance Committee at its meeting on 16 September 2016 consider the questions posed by the Board and report back to the Board through the Chair Report responses.

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

Jo Moore, Chair of the FPBD Committee tabled the Chairs report from the meeting held on 25 July 2016 which was noted.

Jo Moore reported on the assurances the Committee received in delivery of the £7m deficit control total by the year end and that in challenging the delivery of CIP the Executive Team were fully engaged in the process reviewing all CIPs on a bi-weekly basis so that there was no surprises at year end.

With regards to the Board Assurance Framework (BAF) the Committee had considered it appropriate that RISK 5A should be split into two risks, both remaining on the BAF. The Director of Finance had been actioned to review the risk and bring back a proposal at the 23rd September 2016 meeting for consideration. The Chair of the FPBD would report any changes to the BAF at the next following Board meeting (7th October 2016).

Jo Moore reported on matters approved at the Committee including the Trusts Reference Costs process and the Q1 Governance submission to Monitor.

With regard to matters for the Board attention it was noted that the FPBD had approved the Communications, Marketing and Engagement Strategy which would be presented to the Board for approval in October.

The Chair thanked Jo Moore for her report which was noted.

214 Chair's Report from the Governance and Clinical Assurance Committee

David Astley, temporary Chair of GACA Committee on 22 July 2016, presented his report on the work of the Committee. He referred to the work of the Infection Prevention and Control team for 2015/16 which was well presented and provided assurance on the delivery of that service across the Trust. David Astley advised that the paper would be presented to the Board at its meeting in October for

formal approval.

David Astley reported on the Gynaecology Emergency Briefing Paper received by the Committee which following the catastrophic event of a maternal death from an ectopic pregnancy in March 2016 a review of the Gynaecology Emergency Department and Gynaecology Emergency care provision was carried out and looked at all aspects of the Gynaecology Emergency provision at the Trust to identify areas of good practice as well as areas that require improvement through both clinical change and investment. GACA reviewed the findings and received assurance that actions were in place to address and improve emergency care services.

David Astley referred to the BAF changes set out in his report that had been included in the BAF paper later in the meeting.

David Astley advised that other areas to highlight to the Board included Board involvement for the CQC mock inspection and self-assessment in December 2016 and that the Committee was undertaking a workshop to review its future role/activity and risks following the meeting in September 2016.

The Chair thanked David Astley for his report which was noted.

215 **Chair's Report from the Audit Committee**

Ian Haythornthwaite, Chair of the Audit Committee presented his report on the work of the Committee from the meeting on 25 July 2016.

Ian Haythornthwaite advised that outstanding actions relating to recommendations from both internal and external auditors had been implemented on a timely basis following a request by the Audit Committee, resulting in an improved implementation rate of recommendations. The committee had noted that the Executive responsible for the area of audit was held to account for delivery of the recommendations. The Trust also received an overall rating of amber and was compliant with NHS Protect Standards. Explained that the committee was assured that an amber rating demonstrated that the Trust was compliant with the standards and that the amber rather than green rating was due to amendments not yet being made to a small number of policies.

With regards to the issues to highlight to the Board, Ian Haythornthwaite expanded further on the comment in the paper and advised that often the NHS Protect reports focused too much on whether there had been fraud and not enough on whether there were issues with the underlying process and actions. He had discussed this with both NHS Protect and the Internal Auditor and had agreed a plan of action should matters of this type arose so that Internal Audit became involved in any review.

The Chair thanked Ian Haythornthwaite for his report which was noted.

The Director of Workforce and Marketing advised that the Annual Report of the PPF Committee had not been included in the papers although was on the agenda. It was agreed that the Annual Report would be taken at the next meeting of the Board.

ACTION 215: The Trust Secretary to add to the next Board agenda the Annual Report 2015/16 of the PPF Committee.

216 **Safety, Experience and Effectiveness Quarter 1 Report**

The Safety, Experience and Effectiveness Report was taken as read. The Director of Nursing and Midwifery reminded the Board that she was looking at how best a lot of the information in the report can be reported in the future that provided outcomes on a page. She felt that this would help the

Board to identify clearly key issues and concerns and support the Trust's quality strategy. The Director of Nursing and Midwifery hope to have the first cut of the outcomes to a page from the end of Q2.

The Director of Workforce and Marketing referred to the page 47, which highlighted the key themes for complaints. She advised that this highlighted inconsistencies in attitudes across the Trust and that the PPF Committee would look at the findings against the Trust's aims and values.

The Chair thanked the Director of Nursing and Midwifery for her report which was noted.

217 Quality, Operational Performance report Period 4 2016/17

The Director of Nursing and Midwifery presented the Performance Dashboard on behalf of the Associate Director of Operations.

The Board discussed the staff turnover rate which had continued to be higher than target (14% against a target of 10%), noting that fourteen out of seventeen areas were rated as red with only three rated green. The Director of Workforce and Marketing advised that the PPF Committee would be looking at the reasons for the higher than anticipated turnover rate on behalf of the Board. She did feel that the 10% target was generally lower than most NHS organisations and that the increase was reflective of the issues being faced by the NHS nationally.

The maternity rate of epidurals not given for non-clinical reasons was discussed and noted that further work on how this was measured or whether it was an appropriate target needed to be undertaken. The Medical Director advised that he was looking at the targets generally as part of the review of the quality indicators.

The Board noted that although the Trust had continued to deliver the performance target rate against the A&E 4 Hour wait there was concern that the Trust had seen the performance steadily decline since April 2016. This, combined with the increase in median arrival to triage time from 14 to 19 minutes demonstrated that the service was seeing increasing pressures.

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

218 Financial Report & Dashboard Period 4 2016/17

The Director of Finance presented the Finance Report and financial dashboard for month 4, 2016/17 and reported that Trust was reporting a monthly deficit of £0.271m against a deficit plan of £0.178 which was a negative variance of £0.093m for the month. Cumulatively the Trust was slightly behind plan by £0.016m and achieved a Financial Sustainability Risk Rating (FSRR) of 2 against a plan of 2. The Director of Finance reported that a detailed review had been undertaken in month 4 to receive assurance that the Trust was still on target to deliver the £7m control total and this was reported through the FPBD. With regards to income, total income in month was lower than plan, predominantly due to maternity and gynaecology not experiencing the same levels of over delivery of income seen in previous months. The Director of Finance felt that income would be back to deliver planned income at year end.

Ian Haythornthwaite referred to the lack of activity in the Catherine suite and asked whether there was sufficient activity to delivery planned income from private patients. The Director of Finance advised that the Catherine Suite was £0.122m behind plan and that there were plans in place to use the suite differently to generate additional income.

Board noted the current status of the Trust's financial position.

219 Future Generations

The Chief Executive updated the Board on the current position of the NHS Liverpool CCG's options appraisal for women's and neonatal services and reported that the pre-consultation period was coming to an end and that the public consultation would commence towards the end of the calendar year.

The Chair thanked the Chief Executive for her update which was noted.

220 Board Assurance Framework

The Trust Secretary presented the Board Assurance Framework and referring the Board Committee reports, reported that changes referred to the reports had been fed into the BAF. The Board noted the comments made earlier in the meeting with regard to risks reported through GACA and FPBD.

Ian Haythornthwaite noted that the corporate risk committee reported into GACA under the current governance framework, but suggested that there were some considerable corporate risks that should also feed into the other two committees, FPBD and PPF. It was agreed that GACA would consider whether it was appropriate to move the reporting requirements of the Corporate Risk Committee to FPBD, noting that as it was an integrated governance structure there was a need for cross committee recognition of risks.

The Trust Secretary reported that both the FPBD and PPF would be reviewing the Risk Appetite Statement for the Trust at their September meetings and that a paper would be presented to the Board in October with any proposed changes to the statement agreed at the April 2016 Board and reviewed at the August workshop.

The Board noted the content of the BAF.

221 Review of risk impacts of items discussed

The Board noted the risks had been discussed.

222 Any other business

None

223 Review of meeting

Conduct of the meeting was excellent with good challenge, scrutiny and assurance.

Date and time of next meeting

7 October 2016

Liverpool Women's NHS Foundation Trust

16/242

TRUST BOARD
Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
3 June 2016	16/144	Chair of the Charitable Funds Committee to provide an update to the Board on the outcomes from the Charity workshop to be held on 5 July 2016.	Chair of the Charitable Funds Committee	September Board 2016	Action ongoing: the next Charitable Funds Committee Chair's report to provide an update on the progress of the development of the Charities Strategy. Next meeting is due to be held in November/December 2016
3 June 2016	16/144	Liverpool Health partners to attend the Board in November to provide a presentation on the work of the Partnership	Chief Executive/Trust Secretary	November 2016	On Target: invitation provided and accepted.
7 July 2016	Board Risk Workshop	Each Committee to review the Risk Appetite Statement and the descriptions of Risks assigned to them on the Board Assurance Framework	Exec lead and Chair of Committee	October 2016	Action Complete: Each Committee has reviewed the Risk Appetite statement approved at the Board meeting in April 2016 (and reviewed at a Board workshop in June 2016). No proposed changes have been referred to the Board for approval.
2 Sept 2016	16/210	The Associate Director of Operations to provide a briefing note on the impact of the impending junior doctors strike (September 2016).	Associate Director of Operations	October 2016	Action Complete: The British Medical issued a statement in September that withdrew planned industrial action for the foreseeable future.
2 Sept 2016	16/212	Associate Director of Operations to bring a report back to the Board in April 2017 that on addressing those areas of partial compliance to the core standards. The Governance and Clinical Assurance Committee at its meeting on 16 September 2016 consider the questions posed by the Board and report back to the Board through the Chair Report responses.	Associate Director of Operations	April 2017	The 2017/18 work plan will include an update for the meeting in April 2017. GACA reviewed the questions raised by the Board at its meeting on 16 September 2016 and a statement is included in the Chairs Report presented to the meeting. See agenda item 16/249
2 Sept 2016	16/215	The Trust Secretary to add to the next Board agenda the Annual Report 2015/16 of the PPF Committee.	Trust Secretary	October 2016	See agenda item 16/250

Agenda item no:	16/244

Meeting:	Board of Directors

Date:	2 September 2016

Title:	Chief Executive's Report

Report to be considered in public or private?	Public

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

Reference/s:	N/A

Resource impact:	-

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

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

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

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

Presented by:	Kathryn Thomson, Chief Executive

Prepared by:	Kathryn Thomson, Chief Executive

This report covers (tick all that apply):

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

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

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

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

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

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

Kathy Thomson.
Chief Executive.

SECTION A - INTERNAL

UKAS Accreditation to ISO 15189: The Genetics service received a successful outcome of 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 that accreditation to ISO 15189:2012 was offered for the scope of accreditation. This is a fantastic achievement by the Genetics Laboratory Team. Who will be invited to the Board in November to receive a personal thankyou from the Board.

Butterfly awards: The Hospital Honeysuckle Bereavement Team has been nominated in the "best hospital bereavement service category" at the Butterfly Awards 2016. The Honeysuckle Bereavement Team provide care for women and their families at the Trust following the death of their baby as a result of early miscarriage (this includes molar and ectopic pregnancies), late miscarriage, termination of pregnancy due to fetal abnormality at any gestation (a lot of our families like to refer to this as compassionate induction), stillbirth and babies who die shortly after birth. If you wish to vote for the team you can do so at: https://thebutterflyawards.com/2016/09/16/best-hospital-bereavement-service-honeysuckle-bereavement-team-liverpool-womens-nhs-foundation-trust/

HSJ Awards: Liverpool Women's Hospital has been recognised for its ground-breaking work, and nominated for two top healthcare awards. In a surgical first the Trust is the first UK healthcare provider to clinically trial and adopt an American electrosurgical device used in procedures such as hysterectomies. The Voyant device was tested by a team of nine surgeons plus theatre staff, across a variety of procedures. The clinical trial showed the surgical benefits of Voyant in the operating theatre, and also demonstrated potential cost savings. The project – headlined 'A Voyant of Discovery' - has been shortlisted in the 'Using Technology to Improve Efficiency' category of the HSJ Awards 2016.

The trust has also been shortlisted for the HSJ's 'Patient Safety' award. This is in recognition of the Trust's pioneering work to reduce Ovarian Hyperstimulation Syndrome (OHSS) on the reproductive medical unit. OHSS occurs in women who are very sensitive to the fertility drugs taken to increase egg production. Too many eggs develop in the ovaries, which become large and painful and in severe cases, dangerous. The project 'Triggering Excellence in IVF' identified those women who were at risk of OHSS both in terms of medical history and in response to ovarian stimulation. New assessment strategies and medications were then administered to these high risk women. The results showed that, following intervention, the number of women suffering with moderate or severe OHSS were more than halved on the unit.

The Teams from the Trust will present the projects to a judging panel in October, with the awards results announced in November.

Memorial Garden: the grand opening of the garden took place on 21st September 2016 with the Lord Lieutenant of Merseyside, Dame Lorna Muirhead and the Lord Mayor of Liverpool, Cllr Roz Gladden officially opening the new facility. The project by Liverpool Women's Charity, was funded by a £12,000 donation from Tesco Bags of Help. Shoppers voted the memorial garden and play area as their chosen project for the donation. The project also received £3000 from the League of Friends.

Sixty guests attended the opening to celebrate the completion of the outdoor area and the recent merger of charity, The Newborn Appeal into Liverpool Women's Charity.

The outdoor play area will be a safe space for young visitors to enjoy while the memorial garden will offer bereaved families a private space within the hospital grounds, to help them cope with the visit to the hospital during difficult and upsetting times

SECTION B - LOCAL

SECTION C – NATIONAL

Junior Doctors Contract: The British Medical issued a statement in September that withdrew planned industrial action for the foreseeable future following their appeal being rejected by the High Court regarding the imposition of the contract.

12 NHS Hospital Trusts to Trail Blaze NHS's Digital Revolution:

NHS England responds to Independent Review

TWELVE NHS hospital trusts have been selected to trail blaze new ways of using digital technology to drive radical improvements in the care of patients.

Known as "digital exemplars", they will each receive up to £10 million from NHS England in a bid to inspire a digital revolution across the health service.

This phased approach to digital implementation follows the recommendations of an independent review, published, by health IT expert Professor Bob Wachter on how the NHS can use technology to improve services.

In line with Professor Wachter's other recommendations, NHS England has previously announced the appointment of a national chief clinical information officer. Professor Keith McNeil, a senior medical leader and former transplant specialist, will ensure that use of technology across the NHS is focused on direct clinical benefit. Professor McNeil will play a crucial role in coordinating both clinical and technical work efforts as the NHS pushes forward in implementing its technology strategy.

The 12 exemplars, the most digital advanced hospitals in the NHS, will deliver a range of initiatives including:

- Real time video links between ambulances and emergency departments to support better care during journeys to hospital
- Electronic detection and alerting of patient deteriorations such as sepsis reducing the number of patients in whom this is missed leading to improved outcomes, reduced mortality and shorter lengths of stay
- Online systems which reduce medication errors by up to half by managing monitoring patients more effectively and alerting clinicians

The digital exemplars will get funding to invest in digital infrastructure such as Wi-Fi to deliver benefits for patients and doctors, nurses and other NHS staff. They will share learning and resources with other NHS organisations through networks. Health Secretary Jeremy Hunt named the hospital trusts selected by NHS England at the NHS Health and Care Innovation Expo conference in Manchester.

They are:

- City Hospitals Sunderland NHS Foundation Trust
- Royal Liverpool and Broadgreen University Hospitals NHS Trust
- Salford Royal Hospitals NHS Trust
- Wirral University Teaching Hospital NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- Luton & Dunstable University Hospital NHS Trust
- West Suffolk NHS Foundation Trust
- Royal Free London NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Taunton and Somerset NHS Foundation Trust
- University Hospitals Bristol NHS Foundation Trust
- University Hospitals Southampton NHS Foundation Trust

Agenda item no:	16/245

Meeting:	Board of Directors

Date:	7 October 2016

Title:	Safeguarding Annual Report 2015/16

Report to be considered in public or private?	Public

Purpose - what question does this report seek to answer?	To provide an overview of safeguarding practice across the Trust and provide assurance that systems and processes are in place to protect vulnerable Children and Adults

Where else has this report been considered and when?	Governance and Clinical Assurance Committee – 16 September 2016

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

Which CQC fundamental standard/s does this report relate to?	Regulation 13 Safeguarding service users from abuse and improper treatment

What action is required at this meeting?	Board is asked to approve the Safeguarding Annual Report 2015/16

Presented by:	Dianne Brown Director of Nursing and Midwifery

Prepared by:	Mandy McDonough Head of Safeguarding Children and Adults

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		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	**X**
This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
This report will not be published under the Trust's Publication Scheme due to exemptions under S41 of the Freedom of Information Act 2000, because such disclosure might constitute a breach of confidence	
This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust	

Executive Summary

All NHS bodies have a statutory duty to make arrangements to safeguard and promote the welfare of children and adults, with a particular emphasis placed on the provision of greater assurance to the Board of Directors and external partners that those at the greatest risk of abuse, regardless of age, continue to be protected within our services.

Safeguarding vulnerable people is a complex process and this year again has been both exciting and challenging in respect to ensuring the Liverpool Women's NHS Foundation Trust (LWFT) respond effectively and efficiently to the challenges of safeguarding both its patients and staff.

The Hospital Safeguarding Board (HSB) and Safeguarding Operational Group (SOG), continues to provide the Board of Directors, Clinical Commissioning Group (CCG) and External Safeguarding Boards (LSCB/SAB) with assurance of our ability to respond effectively and demonstrate accountability, for all aspects of safeguarding Children and Adults.

This year, the continued progress and reputation of the Safeguarding Service has led to recognition from other provider Trust's and in January 2016, the Team were commissioned by Birmingham Women's Foundation NHS Trust to complete a Safeguarding Peer Review, in preparation for a CQC Inspection. In partnership with the Royal Liverpool and Broadgreen University Hospitals NHS Trust, they have undertaken a Safeguarding Unannounced Inspection and provided a 'Safeguarding Inspection Report' with recommendations prior to their CQC Inspection.

In recognition of their work to transform the Safeguarding Service, developing a robust and dynamic service that promotes safeguarding as everybody's responsibility, they were the winners of the 'Team of the Year' Award at our prestigious 'Dedicated to Excellence Awards'.

Although much has been achieved over the past 12 months, this annual report reflects only on the key safeguarding activities and achievements for children and adults for the period 01 April 2015 to 31 March 2016 and a synopsis of the objectives for future development, incorporating the work of the Safeguarding Team, supported by the Hospital Safeguarding Board.

It also provides the Board of Directors assurance that the Trust now has the effective systems and processes in place to safeguard patients who access services in the

Trust and demonstrates that the Trust is meeting its statutory responsibilities in relation to safeguarding.

Over the coming year the Safeguarding Team has identified several priorities, which are outlined within this report, all of which are central in supporting core activities in safeguarding children and adults.

Board Approval

I would request the Trust board receives and approves this annual report.

Once approved this annual report will be submitted to the Liverpool, Sefton and Knowsley Safeguarding Children's Board's and Safeguarding Adult Board and become a composite with other partner organisations.

Dianne Brown - Director of Nursing & Midwifery/Executive Director for Safeguarding.

Contents

1. Introduction

Liverpool Women's NHS Foundation Trust (LWFT) understands and acknowledges that safeguarding children and adults is everybody's business and that everyone working in health care has a responsibility to help prevent abuse and to act quickly and proportionately to protect children and adults when abuse is suspected.

The purpose of this document is to provide an overview of Safeguarding within the Trust for the period 1st April 2015 – 31st March 2016.

'Safeguarding Mission Statement'

'The Safeguarding Team aims to support all Liverpool Women's NHS Foundation Trust staff in contact with patients to recognise, report and prevent the abuse of vulnerable children, adults and staff, through raising awareness, providing appropriate training and investigating all allegations of abuse.'

The Safeguarding Team is fully established as a multi professional safeguarding unit. The Team comprise of Senior Acute Care Health and Social Care Professionals with experience in Midwifery, Paediatrics, Surgery, A&E, Critical Care, Elderly Care and Social Care, who act both strategically and operationally in preventing and investigating abuse.

The primary objective of the Integrated Safeguarding Team is to provide an effective, efficient and appropriate service to patients and staff of LWFT, who require safeguarding from abuse, whether it physical, financial, sexual, racial, emotional / psychological or neglect.

Key aspects to achieving this objective are effective communication with both partner agencies and within the Trust. Timely intervention to response and recognition of abuse is paramount in order to ensure patients are safeguarded. The team strive to improve this through:

1. Ensuring staff are trained in identifying abuse and have the knowledge to report the abuse.
2. Supporting staff during the referral process.
3. To continue to work in partnership both operationally and strategically to address abuse and promote safeguarding to the patients of Liverpool Women's NHS Foundation Trust.

Since the initial Peer Review in August 2014, commissioned by the Director of Nursing and Midwifery, the Trust Safeguarding Team have effectively integrated and

implemented relevant processes and recommendations in conjunction with continuing financial austerity and change across other partner agencies.

Maintaining the consistency and quality of all aspects of safeguarding practice across the Trust has been essential and a particular focus has been on ensuring effective strategic Safeguarding leadership was in place, establishing robust governance and assurance processes and developing an effective Safeguarding Strategy.

The foundations to promote a joined-up approach viewing safeguarding as a continuum from the unborn baby until older age, combining both child and adult safeguarding have now been successfully established and moving forward, much of the focus is on embedding and ensuring effectiveness of those systems and processes.

2. National and Local Safeguarding Developments

The following demonstrates some of the significant changes in statute and guidance, introduced this year. This ensures statutory agencies respond as appropriate to the diverse challenges present in Safeguarding as a whole. Liverpool Women's NHS Foundation Trust have assessed all necessary information and reviewed the Trusts current process and with the current processes now in place, envisage no risks/problems to be encountered.

Independent Inquiry into Child Sexual Abuse (previously the Goddard Inquiry)

In recent years, there have been increasing numbers of reports of child sexual abuse in a number of institutions, including in the BBC, the NHS, in children's homes and in schools.

In March 2015, under the Inquiries Act 2005 the Home Secretary established a statutory inquiry into the extent to which institutions in England and Wales have discharged their duty of care to protect children from sexual abuse.

The inquiry will investigate whether public bodies and other non-state institutions have/had taken seriously their duty of care to protect children from sexual abuse in England and Wales.

The Inquiry seeks to identify institutional failings and where they are found to exist, will demand accountability for past institutional failings; it will support victims and survivors to share their experience of sexual abuse and will seek to make practical recommendations to ensure that children are given the care and protection they need.

As we all have a duty of care to protect children from sexual abuse, there is already an increased scrutiny for organisations to ensure that statutory and contractual duties are fulfilled with regard to the recording and reporting of child sexual abuse. However, it is envisaged that the inquiry will lead to major changes in standards and safeguarding arrangements across all organisations.

The inquiry is not expected to reach its final stages for many years, however, LWFT are already in a state of preparedness for organisational process review and scrutiny and have the evidence for this assurance, with the submission of:

- Quarterly KPI submissions
- Annual Section 11 Audits
- Merseyside Safeguarding Annual Audit Tool

On 4th August Dame Lowell Goddard resigned as chair of the Inquiry with immediate effect. The chairs position has been subsequently occupied by Professor Alexis Jay OBE.

Mandatory Reporting Duty for Female Genital Mutilation (FGM)

A new mandatory reporting duty for FGM was introduced via the Serious Crime Act and came into force on 31 October 2015, following a public consultation. The duty now requires regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18-year-olds to the police.

An estimated 137,000 women in the UK are affected by female genital mutilation (FGM). However, the true extent is unknown, due to the "hidden" nature of the crime.

FGM is child abuse and an extremely harmful practice with devastating health consequences for girls and women. Some girls die from blood loss or infection as a direct result of the procedure. Some women who have undergone FGM are also likely to find it difficult to give birth and many also suffer from long-term psychological trauma.

In order to improve responses to FGM the multi-agency processes need to be agreed across Liverpool, which will help commission the services to support women who have experienced FGM as well as safeguarding women and girls at risk of FGM. The HSCIC collects all data on FGM within England on behalf of the Department of Health (DoH) and NHS England (NHSE), however a Pan-Merseyside Policy which will require agreement between all agencies is required in order for data collection and responses to FGM to be robust.

As part of this work stream, the Head of Safeguarding has developed strong working relationships with many of our external partners such as Police, Local Authority and representatives from black minority ethnic communities. This has led to development of the Harmful Practices Group which is now responsible for developing a Pan-Merseyside Policy and procedure and raising awareness among professionals and practitioners of harmful practice such as Forced Marriage, Honour Based Violence and Female Genital Mutilation.

Safeguarding Adults: Roles and Competences for Health Care Staff

In 2015, on making arrangements to safeguard and promote the welfare of adults at risk of harm and abuse under Sections 42 to 48 of the Care Act 2014, NHS England published ‘Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document’.

This guidance has been developed in response to policy developments, including Transforming care: A National response to Winterbourne View Hospital (2012), the Care Act (2014) and common themes and lessons learnt from NHS investigations

into matters relating to Jimmy Savile, which all identified the need to improve the safeguarding skills and understanding of health staff.

This statutory guidance will have little impact for LWFT as the Trust already supports the statutory requirements outlined with the Named Nurse for Safeguarding Adults role and compliance with Level 3 Safeguarding Adult Training.

Learning Disabilities CQUIN Guidance

In March 2016 the 'CQUIN Guidance for 2016/17' confirmed the inclusion of a CQUIN indicator for patients with learning disabilities and their families and carers.

The indicator is designed to promote the delivery of excellent care and parity of esteem for all people with learning disabilities by ensuring that people with learning disabilities have access to the same investigations and treatments as anyone else and that their needs are accommodated. This is achieved by ensuring early on in the care pathway there is:

1. Thorough assessment of needs
2. Provision of tailored, patient centred and reasonably adjusted services
3. Good communication

As the Trust already supports the statutory requirements with the Named Nurse for Safeguarding Adults role, we are already now compliant with the requirements outlined in the CQUIN.

Review of the role and functions of Local Safeguarding Children Boards

The many recent changes in local government, including devolution, and other changes in the children's services structures, has led to a review commissioned by the government. Alan Wood, Corporate Director of Children and Young People's services (Hackney) has completed the review into the role and functions of Local Safeguarding Children Boards., the findings of which were published in May 2016.

Although still in the initial stages, the review, made up of 34 recommendations, will be the biggest shake up in safeguarding children arrangements since the 1970s' and it is anticipated that findings from the review will form the basis of provisions to be introduced during the passage of the Children and Social Work Bill.

It is important that key changes continue to underpin all the Trust's values and health care activities. Although the review may lead to some fundamental differences and changes within both practice and the law, LWFT will respond to the changes as appropriate when directed from the Boards.

3. Summary of Current Position

3.1 Safeguarding Specific Objectives for 2014-2015

Significant progress has been made with safeguarding adults and children's work plans and objectives. These still require embedding.

	Objective	Progress	RAG
Audit Plan	1. No standalone Safeguarding Audit Plan currently exists. Audit Plan to include: • Capturing the voice of the Child • Learning Disabilities data • Dementia Care strategy activity	✓ Safeguarding has developed its own internal audit plan as well as a number of audits which follow the Trusts Audit framework. Specific Learning Disability CQUIN has been agreed with the CCG.	
Safeguarding Dashboard	1. Development of Safeguarding Dashboard for GACA and HSB and when the new referral process is embedded (September 2015) capture the data from that report. We plan to build on this data capture as the referral process becomes more utilised across the organisation.	✓ Safeguarding contribute to both the quarterly Trust-wide SEE report as well as the Safeguarding Quarterly Performance report which follows the Trusts Governance framework.	
External Safeguarding Agenda's	1. Development of Clinical Safeguarding Supervision practice across the organization	✓ 12 LWFT Staff have been trained by NSPCC to provide clinical Safeguarding Supervision to all appropriate Trust staff. Safeguarding Supervision policy has subsequently been updated and rolled out, Trust management plan agreed.	

	2. Ensure partnership working with external agencies around Child Sexual Exploitation	✓ LWFT Safeguarding has developed links with Merseyside Police and the CSE Co-ordinators. LWFT are now able to flag patients at risk of or victims of CSE.	
	3. Further develop the Trusts internal and external processes for addressing Female Genital Mutilation (FGM)	✓ LWFT is part of the newly formed Pan-Merseyside Harmful Practices Group which are responsible for the development for policy and procedure around FGM, Forced Marriage and Honour Based Violence (HBV).	
	4. To increase training compliance across all Safeguarding training programs and test their effectiveness	✓ Safeguarding training compliance has increased to an acceptable compliance rate for both the CQC and Commissioning across all levels of training.	
	5. To increase compliance with NHS Safeguarding Standards Merseyside Audit Tool and the Section 11 Audit requirements	✓ LWFT Safeguarding has submitted both these annual audits which showed an increase in compliance.	

4. Risk, Performance, Governance and Assurance

4.1 Risk

4.1.1 Board Assessment Framework (BAF)

There is currently one risk on the Trust BAF (1732) which was monitored by the Hospital Safeguarding Board. This was originally scored as a 20, however due to the completed progress in the Safeguarding Service the score has been reduced to 15.

4.1.2 Safeguarding Service Risk Register

Due to the volume of work already completed within Safeguarding, it was agreed via the Hospital Safeguarding Board (HSB) that these risks were to be reviewed. Any risk items that were already mitigated or achieved were archived and any key issues that were continuing or achieved but not yet tested were transferred in to a new risk item (1895). This risk item, which is scored at 9, continues to be monitored by HSB.

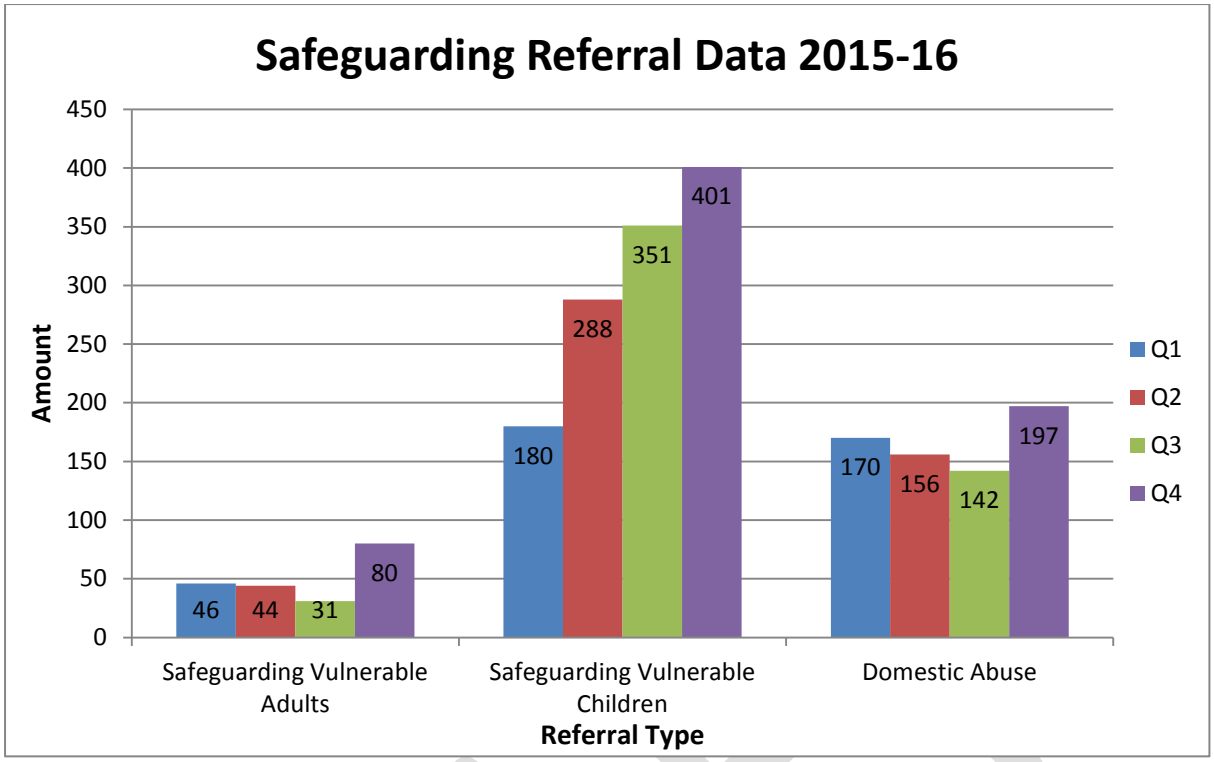
4.1.3 Safeguarding Risk Matrix Proposal

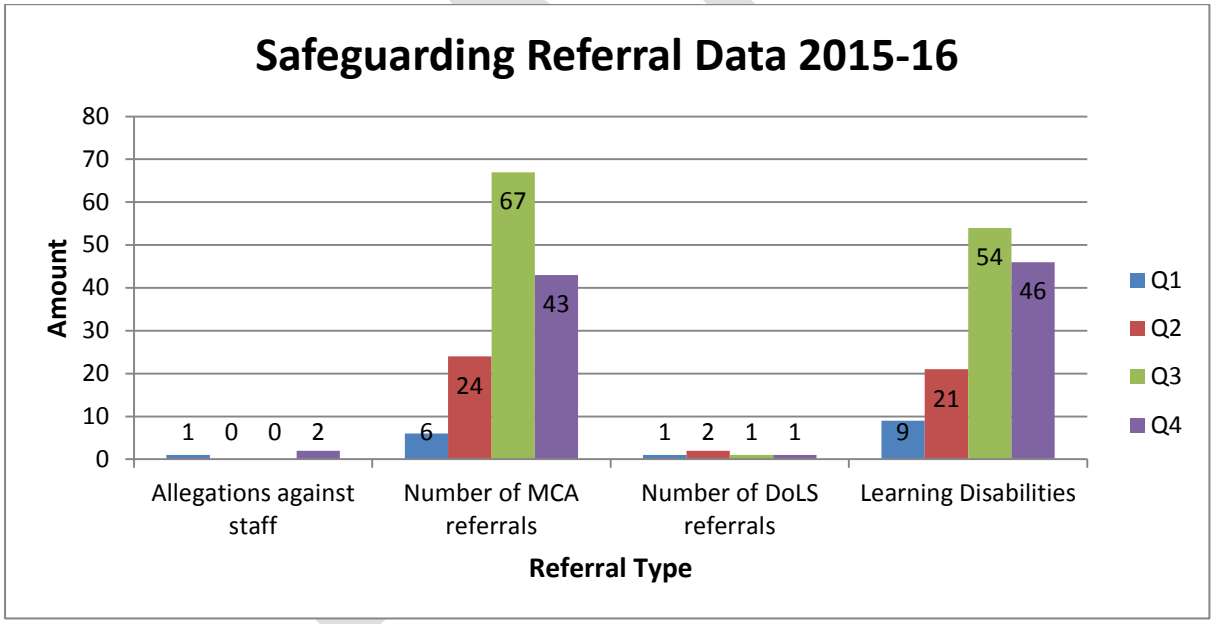
The Safeguarding Team have developed an individual category to be added to the Trusts Risk matrix proposal as a guideline to assist the Trust in scoring risk items pertaining to Safeguarding. This was presented to HSB and agreed that the proposal provides a structure of decision making around Safeguarding and clarified the escalation process. This is an area of work for 2016-17.

4.2 Performance

4.2.1 Safeguarding Performance Data

The newly developed Safeguarding referral process (September 2015) has shown a steady quarterly increase of referrals into the Team. This is reported in the Trusts Safety, Effectiveness and Experience (SEE) Report for 2016-17, as this referral process becomes more embedded and utilised within the organisation, we plan to build on this data capture and report back key themes and trend analysis across all departments.





4.2.2 CCG KPI Reports

In April 2015, the CCG reported limited evidence of assurance in some areas as part of their annual feedback within the KPI Report. Despite progress being made in the months prior e.g. policy, work plans and strategy development there were still a number of elements that required further work e.g. training, safeguarding supervision and partnership working.

In keeping to the approved strategy and work plans developed from the identified strategic risk (item 1732), progress has continuously been made within the last 12 months to increase compliance. The annual feedback from the CCG now reports a steady upward trajectory for the CCG to have full assurance in the Trusts Safeguarding Service.

This progress has been most notable within:

1. Training
2. Safeguarding Supervision
3. Partnership working
4. Policies and Procedures
5. Looked After Children
6. Internal referral processes

The outstanding areas required to attain full assurance remains as:

1. Early Help Agenda
2. Voice of the Child

As part of the Safeguarding Teams objectives for 2016-17, improvement in compliance within the outstanding areas will be our aim.

4.2.2 Liverpool Safeguarding Children Board (LSCB) Section 11 Audit

The *'NHS Standards for Safeguarding Self-Assessment Monitoring Audit Tool'* and the external Safeguarding Boards *'Section 11 Audits*', remain integral as a framework to demonstrate to commissioners and external boards that as providers we have the appropriate comprehensive and effective single and multi-agency policies and procedures to safeguard children and vulnerable adults.

Following the Trusts Section 11 Audit self-assessment in 2014/15 the decision was made by Liverpool LSCB to review the process in which organisations submit evidence to provide assurance around their processes to safeguard children.

In April 2015 the LSCB, a new online system for submitting evidence was introduced. This new system allows providers to continually update the system with new evidence e.g. a policy review or a new audit. Any areas within the audit that the Trust could not provide full assurance for could be subtracted to create organisational action plans to monitor compliance. LWFT have updated the system throughout the year ensuring Section 11 compliance and accurate recording.

The Audit will be reviewed and scrutinised by the LSCB in May 2016 with the scrutiny panels between the providers and board being held in the coming months.

4.2.3 Merseyside Safeguarding Standards Annual Audit

As of April 2015, the CCG reported limited assurance as part of their annual feedback within the Merseyside Safeguarding Standards Annual Audit. Continual progress has been made progress within the last 12 months to increase our compliance and in April 2016, the annual feedback reported the CCG as having a much greater assurance in the Trusts Safeguarding Service. There are now only two remaining areas requiring further assurance; the Early Help Agenda and the Voice of the Child. In order to improve assurance in these areas and continue in strive to achieve our strategic aim, these will remain a priority for the Safeguarding Team over the next 12 months.

4.3 Governance

4.3.1 Policies

With the publication of updated legislation and national guidance such as:

1. Working Together to Safeguard Children (March 2015)
2. Looked after children: Knowledge, skills and competences of health care staff; Intercollegiate Role Framework (March 2015)
3. Prevent Training and Competencies Framework (February 2015)
4. Children and Families Act (2014)
5. The Care Act (2014)

The Trust has had to ensure that all safeguarding policies are updated and accurate, although the Trusts policy is to ensure policies are reviewed every 3 years, Safeguarding policies are now reviewed every 6 to 12 months due to the regular changes in guidance and law.

4.4 Assurance

4.4.1 Hospital Safeguarding Board (HSB)

The HSB drives the organisation by ensuring that safeguarding arrangements within the Trust are regularly reviewed through quality and scrutiny processes, thus providing assurance to the Trust Board that LWFT is effective in meeting its statutory obligations and any locally agreed objectives.

The Terms of Reference include representation from the Designated Nurses (CCG), who provides the strategic overview and scrutiny across all aspects of Safeguarding.

In the last 12 months, the HSB has mainly focused on monitoring progress with serious case reviews, engagement with external partners as well as implementing the new Safeguarding Training Strategy and internal referral process.

This year, the HSB has completed a review of the Terms of Reference in which the body of work encompassed within the HSB was clarified ensuring that the following items were continuously discussed:

- Partnership Working
- Risk
- Training
- Serious Case Reviews (SCRs)
- Domestic Homicide Reviews (DHRs)
- CCG Key Performance Indicators (KPIs)
- Governance
- Assurance
- Effectiveness
- Performance
- Serious Incidents / Root Cause Analyses
- Legislation and National/Local guidance changes

In 2016/17 the HSB will continue to ensure a high level of engagement with external partners as well as maintaining high compliance with the CCGs KPI reports.

4.4.2 Safeguarding Operational Group (SOG)

The Safeguarding Operational Group (SOG) which feeds into the HSB map the workload presented to the Group by HSB. Throughout 2015/16 the group created small working groups or task and finish groups to embed new processes within the Trust in relation to Safeguarding as well as completing outstanding actions from serious case reviews and external audits to improve assurance.

This meeting is chaired by the Safeguarding Manager with the Named Nurse for Safeguarding Adults supporting as Vice Chair and the following is the membership of the group:

- Named Nurse for Safeguarding Adults
- Named Midwife or Safeguarding Children
- Perinatal Mental Health Advisor
- Supervisor of Midwives representation
- Enhanced Midwifery Team representation
- Health Visitor Liaison Manager
- Corporate Quality and Safety Representation
- Clinical divisional representation (Maternity, Neonatal and Gynaecology)
- Equality and Diversity Manager

- Mental Health representation
- Child Death and Overview Panel (CDOP) representation
- Learning & Development representation
- Trust wide Human Resources and Organisational representation (as required)

The Terms of Reference were re-reviewed in December 2015 as a higher level of assurance was attained to alter the frequency of the group from monthly to bi-monthly.

5. Training

5.1 Safeguarding Level 1 and 2

In December 2014 the Safeguarding Training Strategy was developed and ratified, which entailed the reformation of safeguarding training for the whole Trust. For greater accessibility and assurance that our staff are trained appropriately, it proposed to merge together a multitude of safeguarding subjects together in to one training programme, this included:

- Safeguarding Children (Level 1)
- Safeguarding Children (Level 2)
- Safeguarding Adults (Level 1)
- Safeguarding Adults (Level 2)
- Domestic Abuse
- Female Genital Mutilation (FGM)
- Honour Based Violence (HBV)
- Forced Marriage (FM)
- Mental Capacity Act (MCA)
- Deprivation of Liberty Safeguards (DoLS)
- Child Sex Exploitation (CSE)
- Prevent
- Human Trafficking
- Learning Disabilities
- Restraint
- Dementia

This training programme replaced previous safeguarding training material and ensured that all staff and volunteers working within the Trust are aware of all necessary safeguarding information. In January 2015, an online learning package was introduced.

Following an organisational decision to reset Safeguarding Children's Level 1 and 2 as well as Safeguarding Adults Level 1 training to 0% compliance and start afresh, a large communication drive followed to support staff. The training module was launched in August 2015 with drop in sessions and support available from both the Safeguarding Team and Learning and Development, with alternative formats for staff that have no IT access. At the end of year the Trust reported a compliance of 71% (975 staff) in just over 7 months marking a huge Trust achievement and one that shows outstanding commitment from the Trust. From Executives to frontline staff, everybody made safeguarding their business.

5.2 Safeguarding Level 3

In January 2015, both Safeguarding Children and Adults Level 3 training programmes were redeveloped and commenced, with a push in the amount of sessions provided to ensure the organisation received a positive compliance trajectory.

In March 2016, all mandatory safeguarding training sessions had reached compliance in line with CCG and CQC recommendations. Moving forward, the necessary singular sessions in conjunction with Learning and Development will be provided and monitored by Safeguarding.

5.3 PREVENT

The aim of PREVENT is to reduce the threat of terrorism by stopping people becoming terrorists or supporting terrorism. The Health Service is a key partner in PREVENT and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients.
National Objectives:

> Objective 1: respond to the ideological challenge of terrorism and the threat we face from those who promote it
>
> Objective 2: prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support
>
> Objective 3: work with sectors and institutions where there are risks of radicalization which we need to address

Liverpool Women's NHS Foundation Trust as a Health Provider will focus primarily on Objectives 2 and 3.

Prevent Training

The Prevent Training and Competencies Framework has been developed by NHS England to provide clarity on the level of training required for healthcare workers; it identifies staff groups that require basic Prevent awareness and those who have to attend Workshops to Raise Awareness of Prevent (WRAP).

There has been a delay in the delivery of the WRAP training whilst a new national training package has been in development. LWFT have two Home Office trained WRAP facilitators. WRAP training commenced in September 2015 as part of the Trusts Corporate Safeguarding Study Day.

Following the decision to disband the Trusts Corporate Safeguarding Study Day, WRAP has been added to the Clinical Combined Studies Day so Maternity staff can continue to receive this training as well as arranging separate Corporate training sessions for other staff to access. As of May 2016 it has been agreed to provide 4 WRAP sessions a month to attain the CCG compliance target of 70% by April 2017.

5.4 Training Compliance

The Trusts compliance levels for Safeguarding training at the end of the 2015/16 period are:

Session	CCG Compliance Threshold (%)	Compliance as of August 2015 (%)	Compliance as of April 2016 (%)
Safeguarding Children Level 1	90%	0%	**87%**
Safeguarding Children Level 2	80%	0%	**87%**
Safeguarding Children Level 3	80%	64%	**91%**
Safeguarding Children Level 4	80%	100%	**100%**
Safeguarding Adults Level 1	90%	0%	**87%**
Safeguarding Adults Level 2	80%	0%	**87%**
Safeguarding Adults Level 3	80%	52%	**80%**
Safeguarding Adults Level 4	50%	100%	**100%**
MCA & DoLS (Advanced)	90%	52%	**80%**
Prevent (Basic Awareness)	90%	0%	**87%**
Prevent (WRAP)	40%	0%	**25%**

Due to the current and ever developing safeguarding legislative requirements and to continue to provide assurance that our staff are trained appropriately, the Training Strategy requires a full review in 2016. This work stream will ensure that all staff are aware of their Training requirements until the launch of the 2018 Training Strategy.

6. Safeguarding Children

Working Together to Safeguard Children (2015)' sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Children Act 1989 and the Children Act 2004. It is important that all practitioners working to safeguard children understand fully, their responsibilities and duties as set out in primary legislation and associated regulations and guidance.

Even though a health professional may not be working directly with a child they may be seeing their parent, carer or other significant adult and have information or knowledge which is relevant the child's safety or welfare.

The Trust supports the statutory requirements for Safeguarding Children with the roles of the Head of Safeguarding who is the Trust's Named Nurse and Midwife for Safeguarding Children and Dr Chris Dewhurst who is the Named Doctor for Safeguarding Children.

6.1 Serious Case Reviews (SCRs)

Working Together to Safeguard Children (2015) also sets out very specific criteria for conducting SCR's. A SCR is undertaken by a Board appointed Independent Author when a child dies, or is significantly harmed and neglect is known and/or suspected to be a factor in the case. Its purpose is to establish whether lessons can be learned with regard to how professionals and organisations can work together to safeguard and promote the welfare of children and formulate action plan's to improve intra-agency working. SCR's are of little value unless lessons are learned from them.

The Safeguarding Team has been involved in four Serious Case Review's, during the last 12 months.

In order to maximise the opportunity to improve safeguarding arrangements, following the published report, an agency action plan for each SCR is produced and is monitored by the Hospital Safeguarding Board which once completed, is then presented to the external Safeguarding Boards.

6.2 Savile Investigation Report

In February 2015 the summary report into the themes and lessons learnt from NHS investigation into matters relating to Jimmy Savile was published. The report details a number of recommendations for all health providers to undertake.

In May 2015 the CCG Safeguarding Service requested that a self-assessment tool that related to all of the recommendations from Savile was completed by all NHS Health Providers and in November 2015, NHS England North published an updated report. LWFT are compliant with the recommendations from these reports and this has been evidenced and submitted to the CCG as part of our quarterly KPI's.

To ensure the organisation remains compliant and the recommendations are embedded across the Trust, the Lampard Report recommendations will form part of the external auditors schedule (RSM) for 2016/17.

6.3 Child Sexual Exploitation (CSE)

Following on from recent published reports into CSE, it is clear that health services and staff have a significant contribution to make in the identification and the supporting treatment of children and young people at risk from CSE and NHS England have recognised CSE as a national priority for all health staff and agencies.

We are aware from the information and statistics currently available, that there are an increasing numbers of reports of CSE and although they do not offer a full account of the scale of CSE across the UK, estimates suggest that 1: 20 people have been sexually abused. In 2014, police statistics show that there were 36,429 recorded sexual offences where the victim was under 18 years of age. Police in all parts of the UK reported that this was the highest number of sexual offences against children in a decade. However, it is widely felt that there are likely to have been many more offences that have not been reported to the police.

As a result of the increasing numbers of reports and as outlined above, an impending inquiry has been established, which will be the largest, most ambitious public inquiry ever established in jurisdiction and some investigations may take several years.

As previously indicated within the report regarding the '*Independent Inquiry into Child Sexual Abuse'* there are currently no implications for LWFT other than all documents pertaining directly or indirectly to child sexual abuses are retained. Once commenced, when contributing to the inquiry there will be open and honest dialogue and access to any relevant information required.

However, in preparation for the impending enquiry, the evidence submitted to the CCG around Section 11 Audits, Merseyside Safeguarding Annual Audit Tool and quarterly KPI submissions; ensures that LWFT are already in a state of preparedness for the assurance that will be required from our organisation.

Building on the foundation work completed by the Safeguarding Team in 2015/16, CSE will remain a priority in the coming 12 months.

6.4 Voice of the Child

Literature consistently shows the need for the voice of the child to be heard in the child protection process so the system can work more effectively for children. The failure to listen to children and to make sure their views are taken into account in child protection cases has been highlighted in many Serious Case Reviews (SCR's). The Working Together to Safeguard Children (2015) guidance recommends the development of local protocols to actively involve children in the child protection system. In order to keep the child in focus during the child protection process, professionals need to:

- develop a direct relationship with the child and gather information from the child about his or her needs or situation
- elicit the child's wishes and feelings
- provide children with honest and accurate information about what is happening and future possible actions
- invite children to make recommendations about services and support they need
- ensure that children have access to independent advice and support that enable children to express their views and influence decisions.

In terms of reducing risks and achieving better outcomes for children at risk, this area of work is something that the Safeguarding Team have identified as needing to develop in the coming year as part of our child protection processes.

6.5 Looked After Children (LAC)

A Looked After Child (commonly referred to as 'LAC') is a child who is accommodated by the local authority; a child who may be the subject of an Interim Care Order, full Care Order or Emergency Protection Order; or a child who is remanded by a court into local authority accommodation or Youth Detention Accommodation.

In addition where a child is placed for Adoption or the local authority is authorised to place a child for adoption - either through the making of a Placement Order or the giving of Parental Consent to Adoptive Placement - the child remains a Looked After Child until a final order has been granted by the courts.

Looked After Children may be placed with parents, foster carers (including relatives and friends), in Children's Homes, in Secure Accommodation or with prospective adopters.

Looked after children and young people are among the most vulnerable groups in society and are statistically less likely to achieve their potential particularly within education and health than other children

Within the Trust numerous Looked After Children access services on a regular basis via the Emergency Room, Bedford, Gynaecology and Maternity services. On each occasion staff are asked to inform the safeguarding team of this young person's admission or attendance. Further to this on each visit staff are requested to contact the allocated social worker or Local Authority for the young person.

Due to the nature of safeguarding, there is a large number of new born babies that are made subject to Interim Care Orders whilst they are present in the hospital and are discharged to Foster Care, Parents or other services. Further to this babies may leave the hospital after their parents have signed a voluntary Section 20 agreement for the Local Authority to accommodate their child whilst further assessments are undertaken or resources put in place. On all of these occasions a copy of the Care Order or Section 20 agreement is placed in the patient's notes and a member of the safeguarding team will assist staff with the often emotional and challenging nature of removing a new born baby.
In July 2016 the CQC published their report "Not Seen, Not Heard", following their review of 50 local area inspections. Although the review found examples of innovative and outstanding care, it found that health and social care services failing to adequately support young people.

Healthcare services and other organisations that work with children and young people have a responsibility to keep children safe and the review found that vulnerable children and young people in England are sometimes not getting the help they need when and where they need it. The report calls on health services to do more for children at risk of harm.

7. Safeguarding Adults

Since the start of 2015 a key priority for the Trust Safeguarding Team has been the promotion of this Agenda across the Trust. Included in this have been educating all staff groups as to their responsibilities in recognising and reporting abuse, the embedding of the principles of the Care Act 2014 in all relevant policies and procedures pertinent to Safeguarding Adults in a hospital setting, embedding the newly published inter-collegiate document for Safeguarding Adults and improving collaborative working within the multiagency setting.

Significant progress has been made over this year in raising awareness with all staff groups, through the delivery of the Safeguarding Training Strategy, of their role in responding to the needs of those adults vulnerable to abuse and whilst there have been minimal referrals to Social Care in respect to allegations of abuse, the Safeguarding Team are now receiving referrals identifying concerns and providing appropriate support and signposting.

It is felt that the tertiary nature of the Trust combined with the limited numbers of adults with dementia, learning disabilities and complex needs, along with the short length of stay patients experience and that the Safeguarding Adult agenda across the Trust being still very much in it's infancy; may be a contributory factor in the low referral rate.

In the respect to multiagency working, significant progress has been made ensuring the views of the Trust are represented and appropriate challenge given at both the Safeguarding Adults Partnership Boards for Liverpool and Knowsley and relevant Sub-groups to these Boards. This includes the appointment of a member of the Trust Safeguarding Team to the position of Deputy Chair of the Health Sub-Group to the Liverpool Safeguarding Board.

Unfortunately, due to circumstances out of the control of the Trust, the frequency and effectiveness of multiagency meetings relating to Safeguarding Adults have been variable over this time. Despite this, closer working arrangements and a standardisation of external processes have been established including the launch of a revised threshold for Safeguarding Adult enquiries in Liverpool.

The Safeguarding team are looking forward to building upon the work already accomplished this year, in 2016/17, endeavouring to increase the identification of potential abuse and referrals as well as working collaboratively with external partners in safeguarding those adults most vulnerable to abuse.

7.1 Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2007)

In response to concerns being raised during a CQC inspection, regarding compliance with the Mental Capacity Act 2005 (MCA) when recording informed consent for a surgical procedure, an audit of compliance was completed in August 2015.

The Act formalises the process for assessing whether a patient is mentally capable of consenting to a proposed treatment or investigation and ensures the individual making the decision for, or on behalf of, a person who lacks capacity is done, or made, in his or her best interests.

In respect to both the capacity assessment and best interest decisions made, none of the cases audited met the required legal standard.

In response a number of recommendations were made including:

- Training for all doctors and delegated professionals in the application of the Mental Capacity Act is made mandatory.
- Current documentation to be amended to provide appropriate prompts to facilitate compliance
- Key staff to be trained to identify and escalate any capacity issues for expert advice and support.

It should be noted that all of the above recommendations were agreed and embedded in practice by the end of 2015 with compliance being re-audited in April 2016.

In respect to Deprivation of Liberty Safeguards (DoLS), training members of staff in identifying patients who may be deprived of their liberty whilst admitted to the Trust was a key priority during this year. It should be seen as a positive that over this year five patients were identified as being deprived of their liberty and the appropriate authorisation process was completed, Whereas, prior to 2015, no patients had been identified.

7.2 Learning Disabilities & Dementia

Building on the dementia strategy that commenced across Liverpool in 2012 and following review and discussion with partner agencies it was agreed that, due to commonalities in strategic and operational approach, the trust would combine both the care of patients with dementia and those with a learning disabilities into a joint strategy that provides the required statutory and contractual assurance.

The strategy focuses on six key areas:

- Ensure a robust training strategy is embedded to meet local requirements.
- Ensure the prompt identification and coding of people with learning disabilities and dementia
- Ensure there is a senior person identified in the Trust with responsibility for patients with learning disabilities, autism and dementia.
- Ensuring people with learning disabilities and autism, families and carers are involved in the process of planning and decision making where appropriate.
- Embedding knowledge and understanding of learning disabilities, dementia and the Mental Capacity Act (2005).
- Ensuring reasonable adjustments are made to meet the specific needs of such patients.
- Introduce accessible information 'easy to read' and offer support to ensure equal access to health services.

Over this year considerable work has been completed to embed the required processes and train Trust staff appropriately to deliver the strategy. This has included the development of key documents, information systems to highlight need and improve communication as well as the delivery of training relevant to roles and responsibilities.

To ascertain performance against the strategy an audit was completed in March 2016 which demonstrated compliance with the criteria audited. It should be noted that as part of the audit the carer feedback was also reviewed and included the following comments:

- ✓ Excellent care, the ward staff were fantastic.
- ✓ It was great to have one person who co-ordinated everything. It was reassuring that the ward staff treated X as an individual and involved me at every stage.
- ✓ Very pleased with the care received – hospital staff were very friendly and accommodating.
- ✓ Staff were friendly and treated us with dignity
- ✓ My sister enjoyed her stay at LWH and felt it was almost like a little holiday. Hospital staff were attentive and accommodating of her extra needs and were very clear when giving information to her and myself (carer).
- ✓ 5 star care, excellent staff.
- ✓ I wish every hospital in Liverpool had a safeguarding team like the Women's and treated people with learning disabilities and their carers this well.
- ✓ Yes. My sister was cared for really well and was shown care and consideration at every point. She was given a small teddy for comfort and was touched incredibly by this.

8. Domestic Abuse

Currently there are 3 Multi Agency Risk Assessment Conference (MARAC) meetings across Liverpool. The aim of a MARAC is to allow for maximum information sharing between relevant agencies within an agreed protocol. It allows for the agencies to identify those most at risk from violence and abuse and thereafter jointly construct a management plan to provide a professional, co-ordinated approach to all reported incidents of domestic abuse. Many victims are afraid of reporting incidence to the police, however the collaboration between partner agencies that are linked through the MARAC process, allows for safe information sharing and collaborative working.

Currently the MARAC processes in Liverpool are under review. Following a directive from the external Adult Safeguarding Board, a decision has been made to pilot LWFTs suggestion of having one Multi Agency Risk Assessment Committee (MARAC) Health Co-ordinator to feed back to the three Liverpool MARAC meetings on behalf of all the Health Providers, which is a major development for safeguarding processes in Liverpool and will be of great benefit to our frontline practitioners and possibly the potential risk to LWFT patients and staff.

In conjunction with this, MARAC/LWFT internal processes are currently being reviewed by the Trust Safeguarding Service and following an internal audit of performance against the Domestic Abuse Policy, a proposal to introduce the Domestic Abuse (CAADA) National Risk Assessment Tool, used by other health providers has been discussed at the Trusts Hospital Safeguarding Board (HSB). The Head of Safeguarding has been in discussion with Merseyside Police and the Local Authority to address this. This work will continue in to 2016/17.

Due to capacity issues, whilst awaiting a full complement of staff within the Safeguarding Team, LWFT have not attended the MARAC meetings across Liverpool. However as per statutory guidance, we have continued to share the information with all 3 MARAC meetings and taken any actions arising from the meetings. As we have now completed the recruitment process and have a full Team of professionals with the appropriate skill mix required, we have agreed to start attending the largest of the 3 meetings, Liverpool North and South, commencing in July 2016.

8.1 Domestic Homicide Reviews (DHRs)

Domestic Homicide Reviews (DHR's) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force in April 2011.

The Home Office (2011) defines DHR as a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself,

LWFT have been involved in completing two DHR's chronology's in this reporting period. In both cases the victims were murdered by their partner, but no recommendations or poor practice points were identified for the Trust.

8.2 Harmful Practices - (Female Genital Mutilation (FGM) / Forced Marriage (FM) / Honour Based Violence (HBV)

The 'Protecting Vulnerable People Agenda' is now a priority area for Liverpool. As such, some preparatory work has been carried out by the Office of the Police and Crime Commissioner and Police, looking at the Strategic Governance required in order to efficiently and effectively meet the demands of this priority. This work has been in consultation with statutory partners and voluntary sector and LWFT's Head of Safeguarding has represented the Trust in the completion of this.

The new structure will:

- Establish a 'PVP Board' that will set the strategic direction/ strategy for each of the PVP themes (e.g. Harmful Practices, Child Exploitation, Domestic Abuse etc.)
- In essence, the Board would replace, and be an extension of, the current 'Management of Children at Risk of Harm' (it will include Adults)
- The Board will report 'up' to the Merseyside Community Safety Partnership, Merseyside Criminal Justice Board and City Region Chief Exec's meetings where appropriate and also feed into the Children's Board and safeguarding Boards
- The sub-groups that currently sit under the MCJB will be replaced (and significantly streamlined) by the Thematic Groups such as the Harmful Practices Group

The Harmful Practices Group, which will feed into the new PVP Agenda, is a Sub-Group of PVP, of which the Head of Safeguarding attends on behalf of LWFT.

The aims and responsibilities of the group are:

- To work in partnership to raise awareness of Harmful Practices within services and the community
- To strengthen strategic partnerships to ensure Harmful Practices is on the agenda of priorities within service provision
- To develop and renew the protocol to standardise best practice response to cases of Harmful Practices
- To influence the development of policies and procedures to deal with Harmful Practices
- To provide a forum for mutual learning and development
- To initiate and support research to formulate a better understanding of the incidence and nature of Harmful Practices within Merseyside and promote the work achieved by the group

The formation of this group will also address the issues around Trust wide data collection of cases known to have FGM is being reviewed, to ensure compliance with the new legislation and data collection for submission. This is a problem within health Providers Nationally.

Until a local Pan-Merseyside Policy is agreed between all agencies, data collection and responses to FGM are not robust. This will be picked up as part of the work stream for the Harmful Practices Group alongside, raising awareness among professionals and practitioners of harmful practice such as Forced Marriage, Honour Based Violence and Female Genital Mutilation.

9 Safeguarding Supervision

Safeguarding Supervision provides a framework for examining a case from different perspectives. It enables staff members to deal with the stresses inherent in working with vulnerable children, young people, adults at risk and their families and empowers them to explore their own role and responsibilities in relation to the families they are working with. Functioning properly, it facilitates good quality, innovative and reflective practice in a safe environment.

Supervision also helps to ensure that Liverpool Women's NHS Foundation Trust is fulfilling its duties and responsibilities as a safeguarding agency; providing a high quality service to children, young people and adults at risk of abuse including their families and meeting the commitments set out in relevant guidance. Supervision forges a line of accountability between the individual, the employee and the organisation

At the start of April 2016, The Trust only had 2 staff trained to provide Safeguarding Supervision; this was previously identified as a risk to the organisation and placed on the risk register. Following a review of the Trusts Safeguarding Supervision policy in October 2015, the Trust sourced a training course from the National Society for the Prevention of Cruelty to Children (NSPCC) to allow the Trust to train 10 additional staff to provide Safeguarding Supervision. This course was completed in January and March 2016 and currently the Trust are developing a management plan for Safeguarding Supervision to be added to the Trusts policy. Once completed the organisation will be able to ensure it is fulfilling its duties and responsibilities as a safeguarding agency.

10 Allegations against Professionals

In order to manage allegations against professionals, every Local Authority appoints a Local Authority Designated Officer (LADO). The LADO works within Children's Services and should be alerted to all cases in which it is alleged that a person who works with children has:

- behaved in a way that has harmed, or may have harmed, a child
- possibly committed a criminal offence against children, or related to a child, or
- behaved towards a child or children in a way that indicates s/he may pose a risk to children. (Working Together 2015)

In this context, the term "professional" includes paid employees, volunteers, casual/agency staff and self-employed workers who will have contact with children as a part of their role. The LADO ensures that all allegations or concerns about professionals or adults working or volunteering with children are recorded appropriately, monitored and progressed in a timely and confidential way, working closely with the Trust's Head of Safeguarding. The LADO is involved from the initial phase of the allegation through to the conclusion of the case, providing advice and guidance to employers and monitoring the progress of individual cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.

In this reporting period there have been 3 cases where the Head of Safeguarding has liaised with the LADO, 2 of which remain ongoing at this time.

11 LWFT Safeguarding Peer Review

In December 2015, as part of the Birmingham Women's NHS Foundation Trust's (BWNFT) programme of work towards a state of preparedness for a CQC thematic inspection, their Director of Nursing and Midwifery and Deputy Director of Nursing commissioned a peer review of their Safeguarding Services. It was felt that a review of this nature would add value to the improvement journey of safeguarding within the Trust, by providing an overview, position statement and assurance thus allowing BWNFT to be able to prioritise key actions and accelerate improvement. Amanda McDonough, Head of Safeguarding Children and Adults (LWFT), was asked to undertake the review and a report detailing the key findings from the review and makes a number of recommendations for the consideration of the Director of Nursing and Midwifery and Deputy Director of Nursing.

The review focused on 4 key lines of enquiry, these being:

- Vision, strategy and leadership
- Governance, accountability, reporting and risk management
- Quality improvement and learning
- Efficient and effective use of safeguarding resources to meet current requirements and future challenge

The review was completed in January 2016 and the report was prepared for the consideration by the Director of Nursing and Midwifery and Deputy Director of Nursing. Although a substantial amount of work, this review allowed LWFT and BWNFT to share best practice and generated substantial income for LWFT.

12 Safeguarding Team Financial Review and New Structure

Over the past 18 months, the processes and structure within LWFT safeguarding service has changed in order to ensure compliance with the safeguarding standards expected of a safeguarding service within a specialist Trust.

The processes for protecting people thought to be at risk of abuse, mistreatment, and neglect are now more effective but do not over-protect them or deprive them of their human rights.

As the previous structure did not have the appropriate skill mix and legislative posts required, the budget overspend was in excess of £100,000. However by year end (2015/16) the new structure has resulted in an overspend of £5,000. More importantly, the structure provides a greater skill mix and expertise within the team that enables the Team to deliver a more robust service which is more accessible to frontline staff. The competencies and experience held collectively within the Team, such as a Children's Social Worker, Midwifery and Nursing staff, a Best Interest Assessor and a member of staff who has specialist knowledge of the safeguarding governance and assurance processes; enhances the effectiveness of the service, as the staff have the confidence and expertise in decision making within their chosen field. This has also allowed for resilience between the roles to ensure that clinical capacity and relevant core and specialist clinical competence within the service is not reduced, resulting in no compromise to the productivity of the service in fulfilling its statutory and clinical responsibilities.

This mix of safeguarding skills and experience has this year enabled the Team to complete Safeguarding Peer Reviews for other providers, in preparation for their Themed CQC Inspections. This in turn has generated £12,000 income for the Trust.

Over the next 12 months, the Safeguarding Team intend to continue to build on marketing their excellent service and regardless of any future developments, the teams main objective is ensuring LWFT continues with its robust, efficient and effective model of safeguarding practice.

Moving forward, LWFT Safeguarding Team are now best placed to build on these foundations and lead on a safeguarding service across other providers, which is an option for consideration when developing shared services within the current review of services as part of the Healthy Liverpool programme.

13. Key Objective for 2016-17

As outlined throughout this report, during the reporting period for 2015/16, significant progress has been made with both the safeguarding adults and children's work plans and objectives and our objectives have all been met.

Aside from further embedding of these developments, the overall objective for the Safeguarding Team for 2016/17 is to:

- ***Ensure that Liverpool Women's NHS Foundation Trust safeguarding arrangements are statutory compliant with appropriate legislation and national/local guidance in respect of those at risk***

This will be done by the following, which will provide the assurances required to demonstrate our objective:

Ensure all Trust staff has the appropriate skill set and understanding to Safeguarding LWFT patients and staff	1. The organisation is linked into the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adult Board (SAB) 2. A programme of internal audit and review is in place that enables the organisation to continuously improve the protection of all service users from abuse or the risk of abuse. 3. Staff working directly with vulnerable adults and children have access to advice support and supervision. This includes clinical and safeguarding supervision. 4. Training Strategy review ensuring staff are trained and given the appropriate skill set and understanding to their role around safeguarding.
The organization to ensure that the child's voice is heard and has an impact on service development and improvement	1. There is a process for ensuring that patients are routinely asked about dependents such as children, or about any caring responsibilities 2. There is evidence that the voice of the child is incorporated within all routine and targeted health assessments, with particular focus on LAC, CPP and CIN/CAF assessments

Ensure there is a culture of listening and learning within the organisation	1. There is a process which allows feedback clearly showing the views of the child/families 2. Lessons learnt from Serious Case Reviews / Individual Management Reviews are disseminated across the organisation 3. Practitioner forums /Staff Open Days / Training events and Staff Surveys to allow staff input in to processes

Agenda item no:	16/246

Meeting:	Board of Directors

Date:	7 October 2016

Title:	Infection Control Annual Report

Report to be considered in public or private?	Public

Where else has this report been considered and when?	GACA - July 2016 Safety Senate Infection Prevention and Control Committee

Reference/s:	Health and Social Care Act 2011

Resource impact:	

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

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

Which CQC fundamental standard/s does this report relate to?	**Regulation 12: Safe**

What action is required at this meeting?	Receive and approve the Annual Report Make recommendations for further inclusions into the work plan for 2016/17

Presented by:	Director of Nursing and Midwifery

Prepared by:	Tim Neal: DIPC

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	**X**
To participate in high quality research in order to deliver the most effective outcomes	**X**
To deliver the best possible experience for patients and staff	X

Other:			
Monitor compliance	X	Equality and diversity	
Operational plan	X	NHS constitution	X

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	**X**
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 purpose of this paper is to present the Infection Prevention and Control Annual Report to the Board to provide assurance of the processes and monitoring in place to mitigate the risk of harm to patients, public and staff.

2. Issues for consideration

The paper identifies progress made against the annual programme of work and identifies success and areas for improvement within the Trust.

3. Conclusion

Considerable progress has been made with the Infection Prevention and Control agenda.

4. Recommendation/s

Board is requested to:

1. Note the assurances of good practice highlighted within the report
2. Note the work planned for the forthcoming year
3. Make recommendations of additions to the work programme

Attached : DIPC annual report 2016

Liverpool Women's NHS Foundation Trust

Infection Prevention & Control Annual Report 2015-2016

Dr Tim Neal, Director of Infection Prevention & Control

Contents Page

TABLE OF ABBREVIATIONS

CCG	Clinical Commissioning Group
CGC	Clinical Governance Committee
CPE	Carbapenamase-Producing Entrobacteriaeceae
CQC	Care Quality Commission
DIPC	Director of Infection Prevention and Control
DNM	Director of Nursing Midwifery
HCA	Health Care Act
HCAI	Health Care Associated Infection
PHE	Public Health England
IPC	Infection Prevention & Control
IPCC	Infection Prevention and Control Committee
IPCN	Infection Prevention and Control Nurse
IPCT	Infection Prevention & Control Team
IPS	Infection Prevention Society
LWFT	Liverpool Women's NHS Foundation Trust
MRSA & MSSA	Meticillin Resistant (Sensitive) Staphylococcus Aureus
NLMS	National Learning Management System
NUMIS	Nursing & Midwifery System
OLM	Oracle Learning Management System
RLBUHT	Royal Liverpool and Broadgreen University Hospital Trust
SSI	Surgical Site Infection
TNA	Training Needs Analysis
TVN	Tissue Viability Nurse

1 Summary of Key Achievements and Main Findings

1.1 Key Achievements 2015/16

The Trust was compliant with the prescribed MSSA bacteraemia target

The Trust was compliant with the prescribed C*.difficile* target

The IPCT has extended SSI surveillance

Increased audit has improved cannula care

Compliance with CPE screening has improved

All IPC audits are now reported through NUMIS

1.2 Main Findings

1.2.1 Education

The IPCT has provided 149 general training sessions in 2015-16.

1.2.2 Guidelines

The Trust Infection Control Policy has been reviewed and updated in line with new Trust guidance.

1.2.3 Environmental and Clinical Practice Audits

142 (100%) environmental and 348 (95%) Clinical Practice Audits have been completed in accordance with the Trust plan.

1.2.4 MRSA

13 neonates were identified with MRSA colonization with evidence of local transmission. One baby developed MRSA infection.
42 adult patients were identified in the Trust with MRSA, 36 were identified by pre-emptive screening. 3 MRSA infections were identified.

1.2.5 C. difficile

There have been no *C.difficile* infections in 2015-16

1.2.6 Bacteraemia

There was one MRSA bacteraemia reported in 2015-16

There were 4 MSSA bacteremia's in 2015-16 (1 Adult, 3 neonate). The Trust's target for this infection is zero Trust attributable cases in adults.

15 neonates had significant Gram-negative sepsis (6 congenital) and 10 neonates had significant Gram-positive infections (6 congenital).

There were 18 E.*coli* bacteraemias in 2015-16 (8 neonate and 10 adults). There is no nationally set target for this infection, although baseline data are being collected.

There were no glycopeptide resistant enterococcal bacteremias in 2015-16

1.2.7 Surgical Site Infection Surveillance

2.0% of caesarean section and 1.2% of gynaecology wounds were identified as infected.

2 Infection Prevention & Control Team Members

During 2015 - 16 the Infection Prevention and Control Team (IPCT) has been supported by a seconded Midwife, and a seconded nurse.

Miss K Boyd
Infection Prevention & Control Analyst (part time 30 hours/week Infection Prevention and Control Analyst, 7.5 hours/week Policy Officer for the Governance Team)
Mrs D Fahy
Infection Prevention & Control Nurse - (1 WTE – 37.5 hours/week)
Dr T J Neal
Consultant Microbiologist – Infection Control Doctor and Director of Infection Prevention and Control (DIPC) (2 sessions / week worked on LWFT site)
Mrs Anne-Marie Roberts
Secondment Link Midwife (16 hours)
Mrs Julie Burns
Seconded Link Nurse (16 hours)

The IPCT is represented at the following Trust Committees:

Clinical Governance - now Safety Senate	Monthly
Patient Facilities & IPCT & G4S	Bi-monthly
Clinical Supplies Meeting	Monthly
Emergency Planning	Bi-Monthly
Health & Safety	Bi-Monthly
Infection Prevention & Control	Bi-Monthly
Medicines Management	Bi-Monthly
Nursing and Midwifery Board	Monthly
Water Safety Meetings	Twice yearly
PLACE	Ad-hoc
Synergy Meeting	Bi-Monthly
Building Planning	Ad-hoc

The Team is managed by the Deputy Director of Nursing and Midwifery who also managed the budget until January 2016, the budget was devolved to the IPCT.
There are no Trust costs associated with the infection prevention and control doctor and DIPC.

3 Role of the Infection Prevention & Control Team

The following roles are undertaken by the IPC Team:-

- Education
- Surveillance of hospital infection
    - Surgical Site data collection
    - National bacteraemia data reporting
    - PHE data reporting
- Investigation and control of outbreaks
- Development, Implementation and monitoring of Infection Prevention and Control policies
- Audit

- Assessment of new items of equipment
- Assessment and input into service development and buildings / estate works
- Patient care/ incident reviews

Infection prevention and control advice is available from the Infection Prevention & Control Team and 'on-call' via the DIPC or duty microbiologist at RLBUHT.

4 Infection Prevention and Control Committee

The IPC Committee meets bi-monthly and is chaired by the Director of Nursing and Midwifery. The Committee receives regular reports on infection prevention and control activities from clinical and non-clinical Divisions/departments.

The IPCT report quarterly to IPCC and the DIPC reports monthly to CGC which also receives minutes of the IPCC meetings. The Governance and Clinical Assurance committee (GACA) receives minutes from CGC in addition to IPCT quarterly reports. The Trust Board also receives an annual presentation and report from the DIPC.

Trust IPC issues, processes and surveillance data are relayed to the public via Infection Prevention and Control posters, patient information leaflets, the Trust website (copy of this report) a notice board in the main reception which is updated on a monthly basis and departmental notice boards in ward areas.

Throughout the year many changes in practice have been initiated, facilitated, supported or mandated through the work of the IPCT and IPCC. Some of these are on a large scale, such as input of the IPCT into large capital projects undertaken by the Trust (see section 9.2) however many appear smaller and take place in the clinical areas as a consequence of audit, observations and recommendations. These interventions equally contribute to the provision of clean and safe care in the organisation. In March 2016 the IPCC examined its effectiveness throughout the year by reviewing action plans and ensuring that actions cited were either completed or no longer required. The following detail some of the changes facilitated throughout the year.

- The Infection Prevention and Control team have increased CPE screening auditing across the Trust
- Environmental Audits and Saving Lives Audits have moved onto the NUMIs system
- Expanded wound surveillance to include groin nodes
- The team has increased cannula audits to weekly to monitor compliance more closely.
- The IPCT have identified that ANTT training is required more frequently this has been rolled out within the Gynecology department initially by the TVN.
- Pool audits have been increased by the IPCT to monitor compliance
- A more formal post discharge surveillance has been established via Meditech, Community midwives and MAU

Although there is progress in some areas, in others significant actions are not addressed in a timely manner

The IPCT has failed to make progress on one ‘non-compliance’ from the Health care act:-

- Provision of surveillance software

The IPCT has also failed to make progress on two actions within the workplan:-

- Expand Wound surveillance to include Perineal Site Infections
- Implement actions identified through RCA for Congenital infections

5 External Bodies

5.1 Health Care Act & Care Quality Commission

The Health Care Act was published in October 2006 and revised in January 2008 and January 2011 as the Health and Social Care Act. This code of practice sets out the criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment where the risk of HCAI is kept as low as possible.

The Health Care Act action plan is a standing item on the IPCC agenda which monitors progress. There is one outstanding standard of the HCA with which the Trust is not fully compliant; (detailed in Appendix A). This relates to surveillance software which is awaiting the implementation of suitable software at the provider laboratory with hope of acquisition by LWH following this.

6 Education

The IPCT has provided 149 general training sessions in 2015-16;

6.1 Mandatory training and Induction:

Mandatory training in Infection Prevention and Control is a requirement for all Trust staff including clinical, non-clinical staff and contractors. The IPCT update the training package annually and ensure that it reflects best practice, national recommendations and issues identified as non-compliant in the previous year. All staff receive training in infection prevention and control every three years either by face to face electronic learning or workbook training and a Hand Hygiene Assessment. Seventeen face to face mandatory sessions have been delivered in 2015-16

Training continues to be provided by the IPCT for medical staff which includes consultants, trainees and ad-hoc mandatory training for corporate services. Seven formal teaching sessions have been delivered by the DIPC throughout 2015-16

Although the majority of mandatory training is delivered by the IPCT team a number of Link Staff also provide training including hand hygiene within their areas.

The IPCT have developed an electronic mandatory training package for both clinical and non-clinical staff. Following discussions with the Training and Development Department the package was implemented in January 2016. The package is now available for all staff to complete however face to face sessions are still available if preferred. The electronic package is incorporated into the NLMS and linked to OLM

6.2 Link Staff

The IP&C link staff meetings are held bi-monthly and Professional Development Days held twice yearly. The programme is organised to reflect current initiatives, implementation of new guidance and reinforcement of any non-compliance relating to IPC. Attendance by link staff at the two development days was 40% and 45% respectively. Link staff meetings and professional development days are included in the TNA provision for Link Staff.

6.3 Training sessions

Training sessions including the use of personal protective equipment (aprons, gowns, gloves and face masks/eye protections) have been delivered to staff in both maternity and gynaecology. The IPCT have face fit tested those staff required to wear FFP3 masks following a risk assessment.16 face fit testing sessions have taken place in 2015-2016.

6.4 Carbapenemase Producing Enterobacteriacae (CPE)

The IPCT team continued to deliver training sessions to clinical staff. The purpose of the sessions were to inform staff of the risks to patients of acquiring CPE and the prevention and management of these incidents

7 Guidelines/Policies

No new IPC Policies have been required. The IPC policy has been updated, separated into 3 policies and 18 SOP's

- Infection Prevention and Control Policy V6
- MRSA Policy V1
- Clostridium difficile Policy V1
- Diarrhoea SOP V1
- Effective Hand Hygiene SOP V1
- Influenza SOP V1
- Isolation Barrier Nursing SOP V1
- Linen SOP V1
- Personal Protective Equipment SOP V1
- Use and Disposal of Sharps SOP V1
- Wound Infection SOP V1
- Norovirus SOP V1
- Aseptic Non Touch Technique SOP V1
- Urinary Catheterisation and Ongoing Care SOP V1
- Peripheral Cannulation and Ongoing Care SOP V1
- Carbapenemase-Producing Entrobacteriaceae SOP V1
- Management of Blood Bourne Viruses SOP V1
- Management of Hepatitis A and E SOP V1
- Management of Inpatients with Viral Infections SOP V1
- Management of Pulmonary Tuberculosis SOP V1
- Management of Known Suspected or at Risk Patients with CJD or other Human Transmissible Spongiform Encephalopathies SOP V1

8 Audits

8.1 ICNA Trust audit programme

The IPCT continue to use the IPS audit tools originally devised in 2004. The audit programme for the year is established and agreed by the IPCC. All areas are audited annually (low risk areas) or twice yearly (high risk areas) by the IPCT. Clinical practice audits (PPE, Sharps and Hand Hygiene) are completed with a minimum frequency of twice yearly by ward/clinical staff. 5 moments of hand hygiene audits are completed by ward/clinical staff monthly.

The IPS Clinical Practice audits, Saving Lives Audits and monthly 5 moments audits are entered onto the NUMIS system allowing real-time oversight of results and compliance by

local managers. A total of 123 Clinical Practice audits and 225 Hand Hygiene audits have been carried out by department staff and have been reviewed by the IPCT

Environmental audits using the IPS audit tools are carried out unannounced by the IP&C Practitioners and where possible accompanied by a member of departmental staff. A total of 142 Environmental scheduled audits (Including general environment, linen, waste and Kitchen) over 26 clinical areas have been carried out by the IPCT. Individual department scores, main themes of non-compliance and areas of improvement are recorded and available on NUMIS.
The audit scores (mean and range) are outlined below:

Audit	Mean Score (%)	Range (%)
Ward Environment	89%	74-100
Ward Kitchen	88%	78-100
Linen	93%	82-100
Departmental Waste	91%	91-100
Patient Equipment	96%	89-100
Hand Hygiene	89%	83 - 100
Personal Protective Equipment	92%	90 - 100
Sharps safety	92%	85 - 100
Monthly 5 moments	90%	70 - 100

In October 2015 Community Midwives audits went live on the NUMIS system for Community Midwife input (a combined self-assessment clinical practice audit of sharps, PPE and hand hygiene). Actions have been discussed with Matron, Team Leaders and the IPCT. The self- assessment tool has been modified in March 2016.

In October 2015 the NUMIS system went live for Saving Lives audits. Departmental staff are responsible for ensuring that monthly observations (as agreed with IPCT) are completed and are displayed along with NUMIS scores on the Trusts standardised IPC notice boards.

The Trust audit process is on target with the planned timetable.

8.2 Peripheral cannula audits

As out lined in last year's annual report the IPCT continue to audit the ongoing care of cannulae in both Maternity and Gynaecology. Following reimplementation of the VIIAD chart and further training the IPC have audited on a weekly basis. Scores have ranged from 60 - 100% with a mean score of 92 % insufficient documentation on the VIAAD chart, is still an area of concern.

8.3 Mattress audits

Mattress audits are completed 3 monthly in Delivery Suite and Midwifery Led Unit, and 6 monthly in all areas. The audit examines cleanliness and mattress integrity. Results are reported through the Divisional Report to IPCC. The audits are forwarded to IP&C Team but local areas have ownership for replacement and condemning of any mattress not fit for purpose. There is a system in place for the provision and storage of replacement mattresses across the Trust. No significant or unresolved issues relating to mattresses have been identified.

8.4 Birthing Pool Audits

Pool audits have been completed on a weekly basis by IPCT. Both MLU and Delivery Suite achieved 100% compliance with the cleanliness of the pool at the time of audit. Areas of non-compliance relate to the documentation of the daily cleaning of the pools and before and after patient use. The IPCT feedback to departments and Matrons. IPCT continue to notify Ward Managers, Matrons and Link staff of audit results.

9 Other Issues

9.1 Water Safety

The water safety group has met in line with its terms of reference. Water testing for Pseudomonas aeruginosa in augmented care areas has been performed in accordance with national guidance and results have been compliant with expected standards. There have been no cases of infection with *Pseudomonas aeruginosa* in the current year.

9.2 Building Projects & Design Developments

Meetings between Estates, Facilities & IPCT have continued. The team remain reliant on the Estates Department and the Divisions alerting and involving the Team in impending projects via the Infection Prevention and Control Committee meetings.

2015-16 projects requiring IPC Team involvement included:

- Midwifery Led Unit
- Genetics moving from Alder Hey to Liverpool Women's

9.3 Waste Contract

It was agreed that the new waste streams should be trialled. The new waste stream / bag to bed trial began in March 2016.

9.3.1 Sharpsmart

The IPCT and IPCC have approved the use of 'Sharpsmart, 'a more environmental friendly sharps disposed system, for use throughout the Trust. This system will be implemented in 2015-16.

9.4 Linen Contract

The Trust changed its linen provider in 2015-16. This contract is monitored by the Trust Facilities Manager.

10 Surveillance of Infection

Hospital infection (or possible infection) is monitored in the majority of the hospital by 'Alert Organism Surveillance' this involves scrutiny of laboratory reports for organisms associated with a cross infection risk e.g. MRSA, *Clostridium difficile* etc.

On the Neonatal Unit, which houses most of the long-stay patients, surveillance is undertaken by both 'Alert Organism' and by prospective routine weekly surveillance of designated samples. The IPCT examines results of these samples and action points are in place for the Unit based on these results.

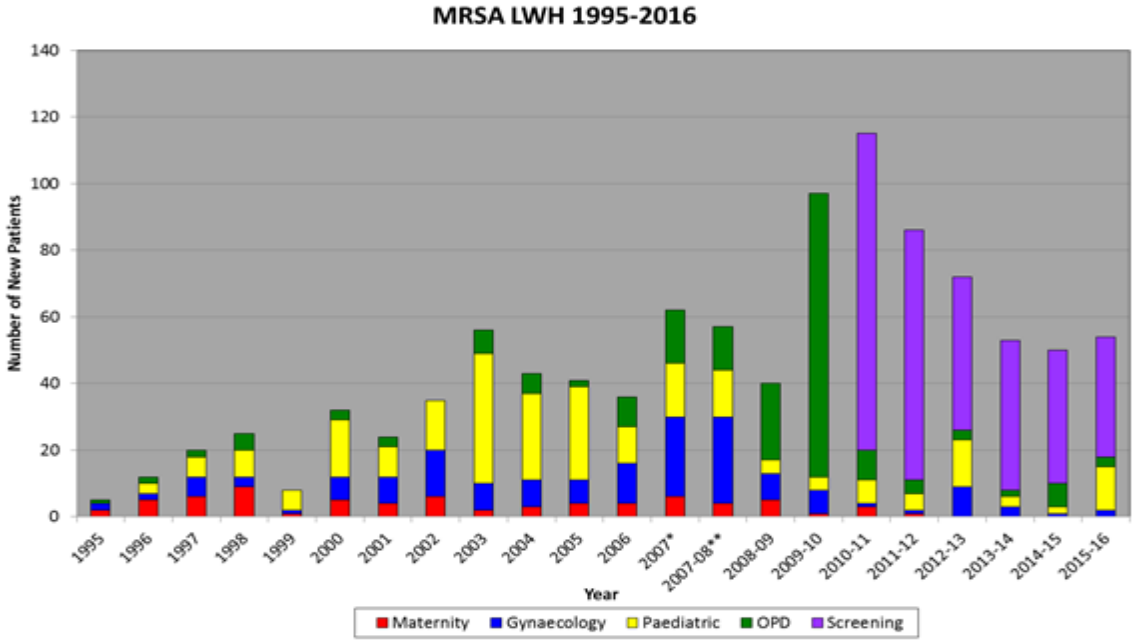
Surveillance of bacteraemias (blood stream infections) for both national mandatory and in house schemes is also undertaken.

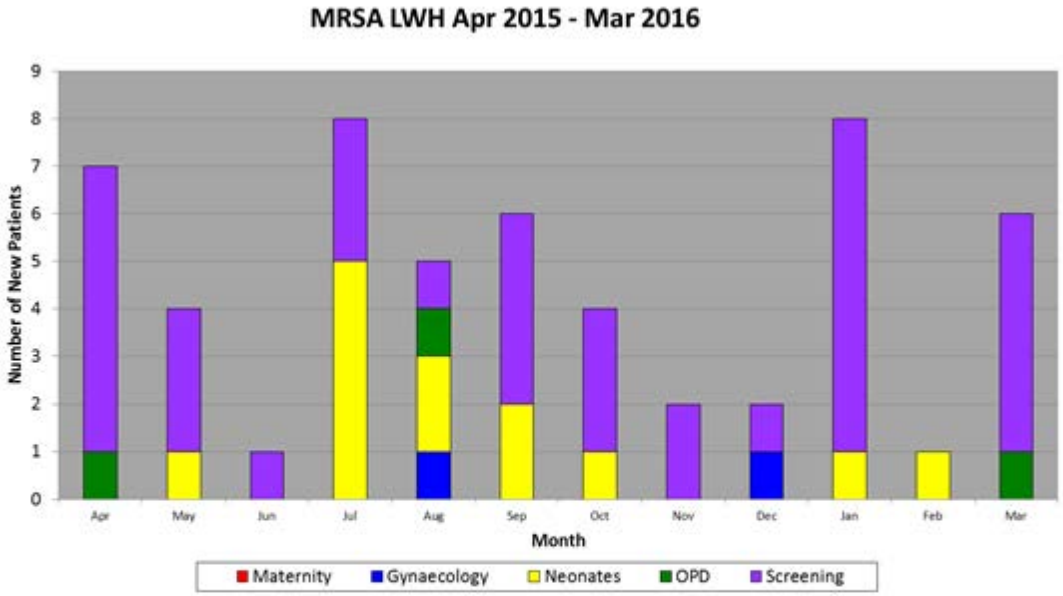
The need for surveillance of surgical wound infections has long been recognised as an important quality marker by the IPCT and Trust. The surveillance system for surgical site infections, restarted in 2014 by the IPCT and has been extended this year.

10.1 Alert Organism Surveillance

10.1.1 MRSA

The total number of patients identified carrying Methicillin Resistant *Staphylococcus aureus* (MRSA) in the Trust during the year 2015-16 was 54, primarily identified from screening samples. The charts below show the number of new patients identified with MRSA per year for the period 1995 – 2016 and the number per month for the current reporting year by provenance.





As outlin

ed in previous Annual Reports the Government have established targets for screening such that all elective admissions and all eligible emergency admissions to hospital should be screened for carriage of MRSA prior to, or on, admission. The IPCT have an MRSA screening policy as part of the infection prevention and control policy which outlines actions for patients found to be positive on screening. The percentage of patients screened in line with this policy is detailed in the table below.

Screening of Elective and Emergency Admission 2015-16												
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% of eligible patients screened	100	100	100	100	100	100	100	100	100	100	100	100

In the period April 2015 to March 2016 9276 adult patients were screened for MRSA carriage. 42 (0.45%) were positive this represents a continued decline in prevalence over the past 5 years.
Six adult patients were identified with MRSA on diagnostic samples from clinical sites. Three were from wounds thought to be infected, and one urine sample, one HVS and one mouth swab were also positive.
There were no clusters or other epidemiological linking of adult patients with MRSA infections. There was no evidence of spread of MRSA amongst adult patients in the Trust.
There were no MRSA bacteraemias in adult patients in the reported year.

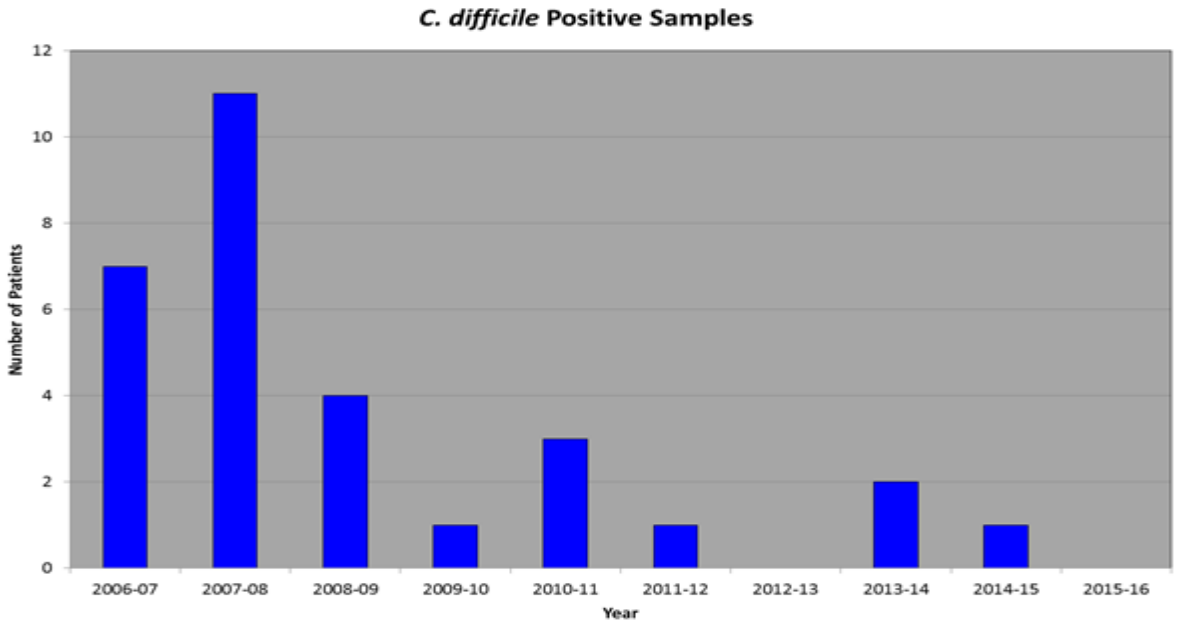
There was one neonatal patient in the Trust identified with MRSA bacteraemia in in the reported year. A full disciplinary review of care was undertaken and it was identified that the infection was secondary to a line infection.

During the period of this report 13 babies were identified with MRSA. 10 occurred over the summer period including one baby with MRSA bacteraemia (see section 11). Three were identified on admission swabs suggesting maternal acquisition.

Updated guidance on screening has been released from DoH in 2015 – 16. This allows deviation from universal screening where local risk assessment identifies that this can safely be achieved. The IPCT are working with directorates to identify patient groups which do not benefit from MRSA screens.

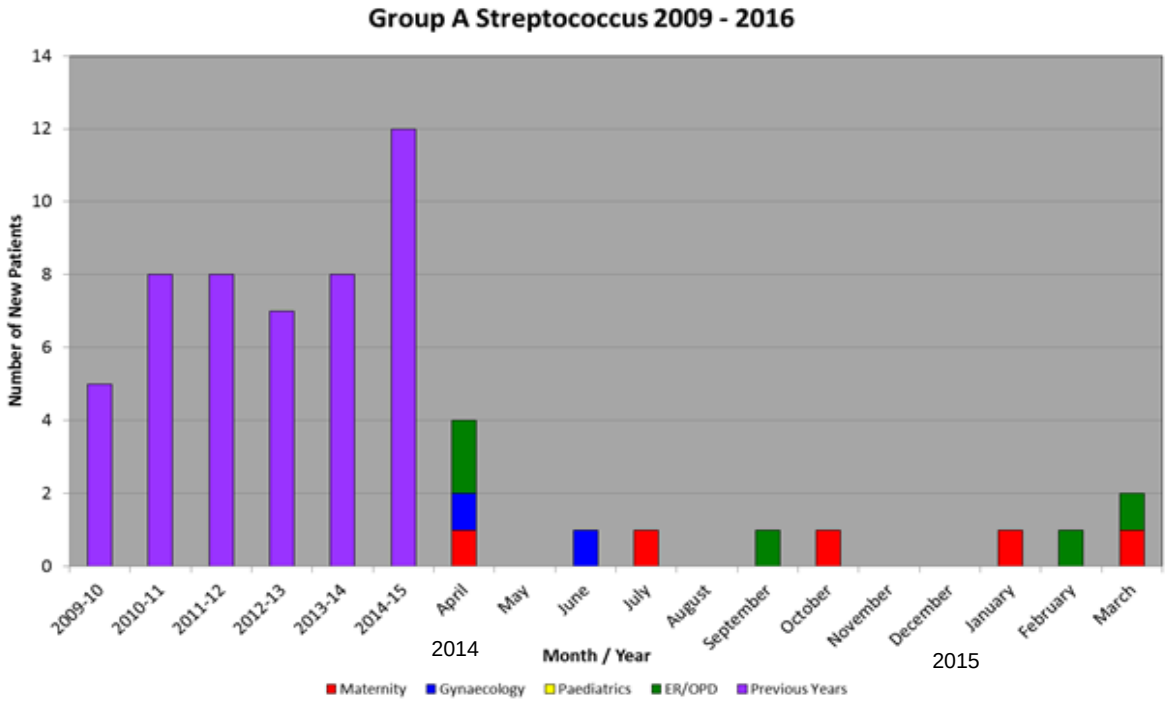
10.1.2 Clostridium difficile

C*lostridium difficile* is the commonest cause of healthcare acquired diarrhoea in the UK. Mandatory reporting of this disease commenced in January 2004 and includes all patients over 2 years old. Historically the number of cases at LWFT has been small (see chart below). During the period April 2015 to March 2016 there were no patients identified with *C.difficile* infection in the Trust.
The prescribed trajectory for this disease for the Trust in 2015-16 was one.



10.1.3 Group A Streptococcus

In the period April 2015 to March 2016, 12 patients were identified with Group A streptococcus as detailed below.



Five of the 12 patients with Group A streptococcal infection were maternity patients (including two from the infant feeding service) Seven were Gynaecology patients, 5 of which presented to the Gynaecology service via the emergency room, the two remaining were ward patients. There was no identified transmission of Group A streptococci in the Trust.

As highlighted in previous annual reports Group A streptococcal infection is being increasingly recognised as a cause of mortality and morbidity in maternity patients. There were no episodes of Group A streptococcal bacteraemia or invasive infection (iGAS), one

patient had tonsillitis, two patients had breast infection and one had infection of a surgical wound. The remaining 8 were isolated from the genital tract of post-partum or antenatal patients.
Isolates were submitted to the national reference laboratory for typing, no epidemiological links were identified.

10.1.4 Glycopeptide Resistant Enterococcus(GRE)

There were no GRE bacteraemia's reported.

10.1.5 Carbapenemase Producing Enterobacteriaceae

The Trust continues to screen patients in high-risk groups (i.e. Patients directly transferred from other Trusts or Patients who have been in-patients in high-risk hospitals within the last 12 months). Meditech facilitates the risk assessment. CPE screening compliance is audited weekly by the IPCT
Overall compliance April 2015 March 2016 = 87%

Month	Screening Compliance
Apr 15- June 15	82%
July 15– Sept 15-	90%
Oct 15 – Dec 15	93%
Jan 16 – Mar 16	84%

The main theme of non-compliance is missed screens on patients who are direct transfers from another hospital. This issue have been addressed with Ward Managers, IPCT Link staff and clinical staff in the relevant areas. IPCT staff have included CPE Screening in an Infection Control update on Maternity Obstetric Training days.

There have been no confirmed cases of CPE, colonisation or infection to date.

10.1.6 Routine Neonatal Surveillance

Nearly all infection on the neonatal unit is, by definition, hospital acquired although a small proportion is maternally derived and difficult to prevent. Routine weekly colonization surveillance has continued this year on the neonatal unit. Results are shown in Appendix E

As colonisation is a precursor to invasive infection the purpose of this form of surveillance is to give an early warning of the presence of resistant or aggressive organisms and to ensure current empirical antimicrobial therapy remains appropriate. Action points are embedded in the neonatal unit and IPC policies linked to thresholds of colonisation numbers to limit spread of resistant or difficult to treat organisms.
As well as resistant or aggressive organisms focus has remained on both *Pseudomonas spp*. and *Staphylococcus aureus* as potential serious pathogens. The median number of babies colonized with pseudomonas each week was 1 (unchanged from previous year) and with *S.aureus* was 5 (increased from 4 the previous year).

1.1 Bacteraemia Surveillance

1.1.1 Neonatal Bacteraemia

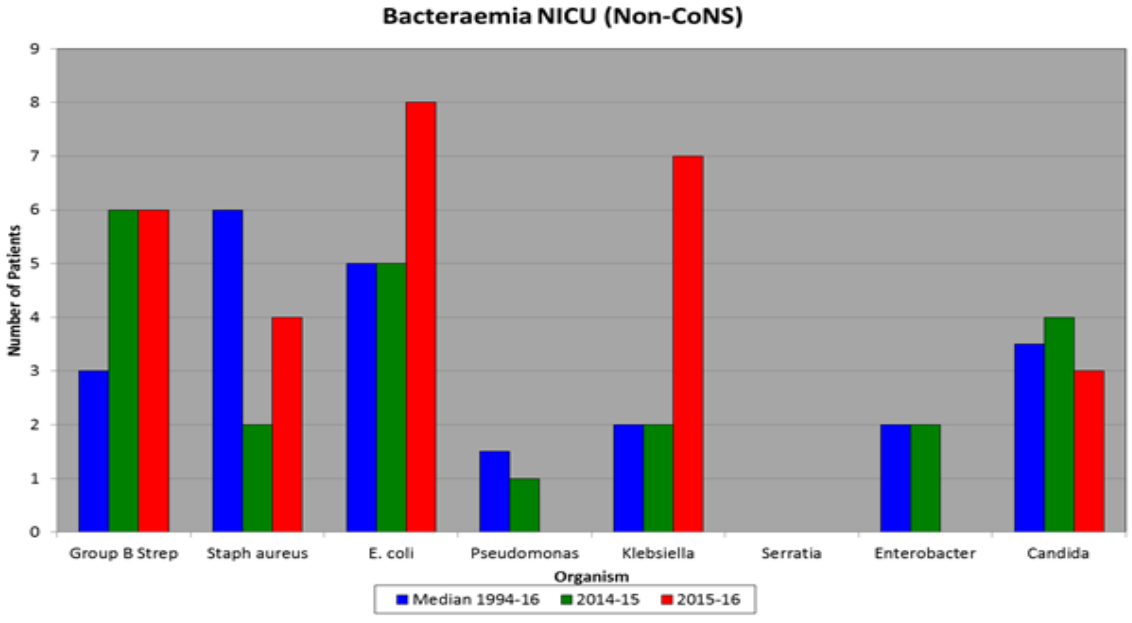
As always the commonest organism responsible for neonatal sepsis was, the common skin organism, coagulase-negative staphylococcus (CoNS). In the period April 2015 – March 2016 15 babies (9 in 2013-14 and 13 in 2012-13) had infections with Gram-negative organisms, 5 of these infections (all *E coli)* occurred in the first 5 days of life and were congenitally acquired, one *E.coli* occurred on day 5 and most probably represented a late presentation of congenital infection. The remaining 9 Gram-negative infections occurred after 7 days (2 *E.coli*. 7 *Klebsiella sp)*

There were 10 episodes of infection with significant Gram-positive pathogens; in 7 cases (6 Group B streptococcus and 1 *S. aureus)* the infection was congenitally acquired. The remaining 3 (1 MRSA & 2 *S. aureus*) occurred after the first week of life.

There were 3 babies in 2015-16 who developed invasive infection with Candida (one congenital).

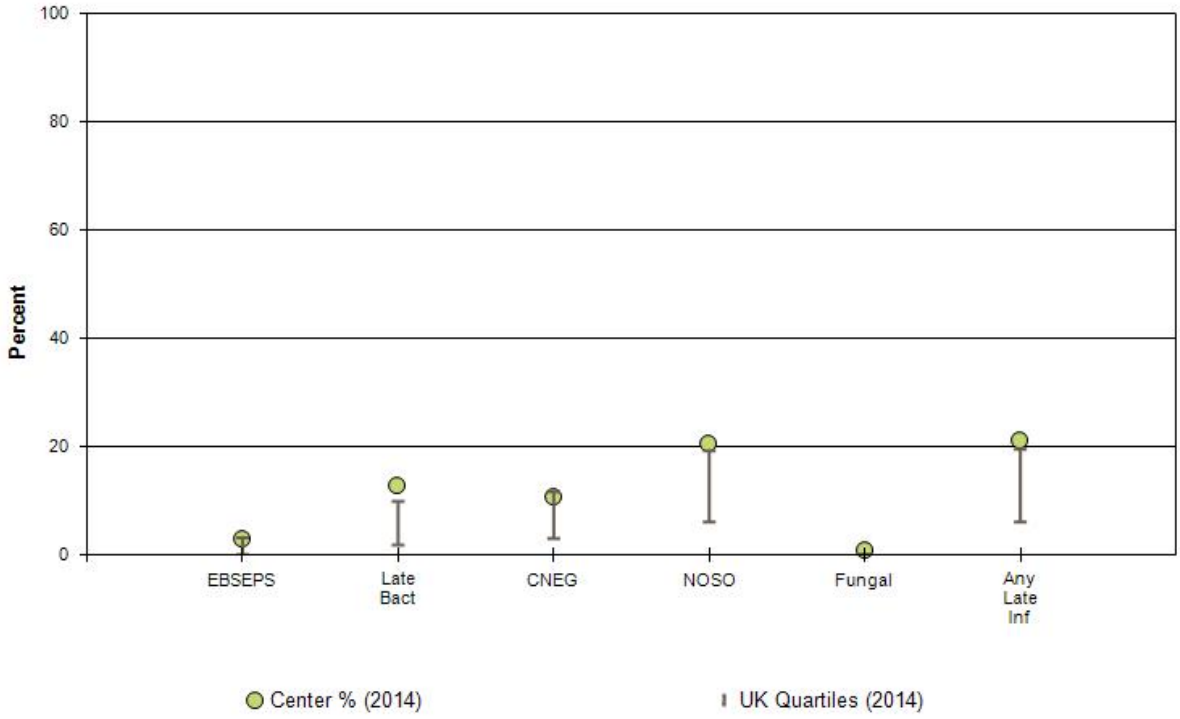
All non coagulase-negative staphylococcal sepsis on the unit is subject to a review to determine the focus of infection, precipitating causes and the appropriateness of care.
The bar chart below describes the pattern of 'definite-pathogen' neonatal bacteraemia in the current year in comparison to last year and the median value for each organism for preceding years. Although there is considerable variability in the figures from year to year (probably reflecting the complex of pathogen host relationship in this group) of significance this year is an increase in both klebsiella and *S. aureus* infections. No common link was established between the patients with these infections. There have been no *P. aeruginosa* bacteraemias in the last 4 reported years.

13 babies this year had congenital infection (9 in 2014-15 and 7 in 2013-14) although it was part of the IPCT work plan to conduct multidisciplinary reviews of care of babies born with infection this has not been possible to arrange due to diary conflicts of the various parties required. Nonetheless this remains a priority for the organisation.



The Neonatal Unit continues to monitor standardised infection rates. The most recent results (2013) of the benchmarking exercise against other units in the Vermont Oxford network demonstrate a sustained improvement in the Trust's position.

VON 2014



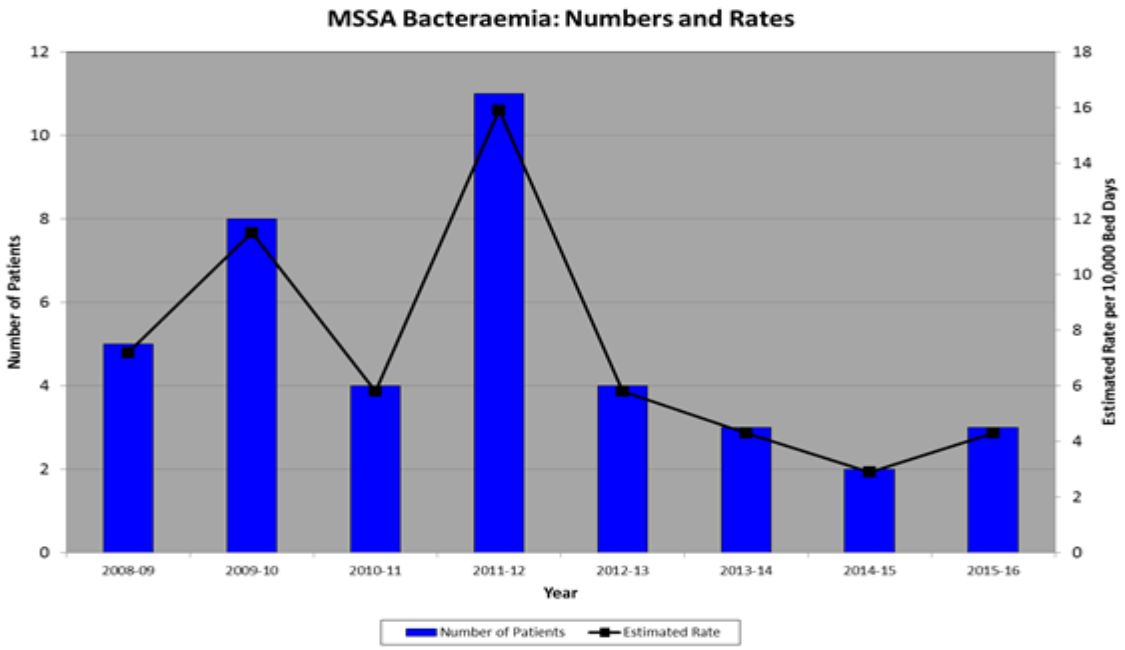
1.1.2 Mandatory Bacteraemia Surveillance

The IPCT has continued to submit infection data to the national mandatory bacteraemia surveillance scheme (instituted April 2001). All positive blood cultures are reported monthly to PHE. National data are collected on *S. aureus*, (MSSA and MRSA) bacteraemia.

In the period April 2015 to March 2016 there was one patient with MRSA bacteraemia (having had zero cases for the preceding 5 years). The Trust's given target for the period was zero.

Although data for Methicillin susceptible *S. aureus* (MSSA) have been collected since 2001 this was not mandatory nor were the data published until January 2011. There have been 4 episodes of MSSA bacteraemia (3 in neonates see section 10.2.1) in the period 2015-16. The adult patient with MSSA bacteraemia was admitted with the infection from the community. Unpublished Trust attributable MSSA data for LWFT for the years 2008-2016 are shown below.

Although there are no externally set targets for MSSA bacteraemia the Trust target is zero Trust attributable cases in adult patients. There have been no Trust attributable MSSA bacteraemia cases in adult patients in the last 2 years.



E.coli bacteraemia has also been made mandatorily notifiable although targets have not yet been established. In 2015 – 16 the Trust reported 8 *E.coli* bacteraemias in neonates (6 categorised as congenital). In the same period there were 10 *E.coli* bacteraemias in adult patients (10 in 2014-15). The IPCT expect clinical areas to undertake a RCA of all significant bacteraemias to establish any elements of sub-optimal care.

In addition to the mandatory surveillance the IPCT has been collecting clinical data on bacteraemic adults in the Trust; 28 patients were identified with positive blood cultures from 290 cultures submitted (10%). 7 (25% of positives, 2% of total) of these were contaminated with skin organisms. Of 21 significant bacteraemias 2 were considered to be possibly healthcare associated. Details are provided in Appendix F

10.2 Surgical Site Surveillance

Surgical Site Infection (SSI) is one of the most common healthcare associated infections, estimated to account for 15% of HCAI. National surveillance for abdominal hysterectomy suggests an SSI incidence of 1.5%. There is no national data for caesarean sections however studies report rates between 2% & 20% with the highest incidence being in emergency sections.

Surgical site wound surveillance in both Maternity and Gynaecology was re-established in 2014 to include all abdominal procedures. In April 2015 wound surveillance extended to include groin node dissections. Data has been collected by a member of the IPCT/TVN using a standard surveillance sheet. Surveillance includes the inpatient period for all patients and the post discharge period until the 30th day.

10.2.1 Maternity

Wound infections are assigned by the time of operation rather than the time infection is recognised i.e. an infection identified in November from surgery in October will be recorded in October's figures.

In the 12-month period (April 2015 – March 2016) 2,300 Caesarean Sections were undertaken (1063 elective, 1237 emergency). 89 patients with potential SSI were reviewed

with 47 fulfilling the criteria for SSI. Of the 47 infections, 12 were in elective and 35 in emergency cases (1.1% and 2.8% respectively).

10.2.2 Gynaecology

2,352 abdominal procedures were undertaken in the 12-month period in Gynaecology / Gynae oncology with 566 procedures being open and 1454 being laparoscopic. The IPCT/TVN reviewed 46 patients with potential infections. 20 SSI were identified, 10 in open and 10 in the laparoscopic category (1.8% and 0.7% respectively).

Groin dissections – 23 groin dissections were undertaken. The TVN reviewed 11 potential SSI's. 8 SSI were identified.

As a number of wound infections are diagnosed post discharge, the numbers actually seen by the IPCT are limited at the inpatient period. Some patients who develop infection post discharge will be captured via community notes (although these often take several weeks to return to the Trust) and patients who represent to the Trust. A more formal process of post-discharge surveillance has been established including additional information on Meditech for MAU post-natal attendees and for community midwife patient discharges.

The number of infections identified so far is small making the identification of common themes difficult. The surveillance will continue and potential themes will be identified in future report.

10.2.3 Perineal Surveillance

According to the IPCT forward plan surveillance of perineal infections should have commenced in January 2015. There was slippage in this date and this surveillance commenced in April 2016

11 Outbreaks of Infection

There have been no major hospital-wide of infection during the period of this report.

11.1 MRSA Colonisation NICU

During the summer months a cluster of patients colonised with the same strain of MRSA was identified on the neonatal Unit. 8 Babies were identified and one developed infection. (A summary is provided in Appendix D).

12 Health & Wellbeing

The Trust Health & Wellbeing Department report monthly to the IPCC including vaccination updates. Staff have historically been screened for TB, Hepatitis B and Rubella immunity. Guidance on measles, chicken pox, HIV and hepatitis C have been incorporated for all 'new starters' and a catch up exercise is in place for staff already employed. The IPCC supports the Health & Wellbeing Team in ensuring that workers in designated areas have appropriate vaccinations and immunity.

13 Infection Control Team Work Plan

13.1 Infection Control Team Work Plan 2015-16

Work Plan	Completion Date	
Training		
• **Continue all Trust mandatory & induction training**	Ongoing	
• **Continue to support link staff personal development**	Ongoing	
• **Implement the bespoke electronic training module**	July 2015	Completed and implemented January 2016 section 6.1
Audit		
• **Continue with ICNA/IPS Audit Programme**	Ongoing	Section 8.1
• **Utilise NUMIS to monitor audit data and compliance:-**		
- **Environmental audits**	June 2015	Completed
- **Saving Lives Audits**	August 2015	Completed

Surveillance • **Continue 'Alert Organism' surveillance focused on resistant pathogens** • **Continue to monitor cases mandatorily reportable infections** • **Expand wound surveillance for surgical site infection to include:-** - **Groin dissection infections** - **A more formal process of post-discharge surveillance** - **Perineal surgical site infections** • **Implement actions identified through RCA of bacteremia's and C.difficile infections:-** - **Congenital**	Ongoing Ongoing April 2015 October 2015 January 2016 Ongoing April 2015	 Commenced section 10.3 Commenced Commenced April 2016 Not commenced section 10.2.1
NICE • **Monitor Saving Lives and additional IPCT audits of cannula care** • **Monitor Normathermia being maintained via Theatre audit** • **Monitor Dress code and human traffic through put in Theatre via audit** • **Sign up to safety sepsis bundle**	Ongoing July 2015	Section 8.2 Completed July 2015 Completed July 2015 Commenced
Health Act • **Monitor through IPCC Trust response to actions outlined in the Health Care Act Gap Analysis**	Ongoing	Section 5

13.2 Infection Control Team Work Plan 2016 - 17

Work Plan	Completion Date	Comments
Training • Continue all Trust mandatory & induction training • Continue to support link staff personal development		
Audit • Continue with ICNA/IPS Audit Programme • Continue Saving Lives audits including cannulation • Continue monitoring of pool cleaning		
Surveillance • Continue 'Alert Organism' surveillance focused on resistant pathogens • Continue to monitor cases mandatorily reportable infections • Expand wound surveillance for surgical site infection to include:- - Perineal surgical site infections • Implement actions identified through RCA of bacteremia's and C.difficile infections:- • Commence RCA of congenital infections		
Health Act • Review compliance and evidence		

NICE • **Review compliance and evidence for QS 61** • **Review Compliance and evidence for QS 113**		

14 Appendices

14.1 Appendix A - Summary of Health Care Act Partial Non-Compliance

Criterion	Additional Quality Elements	Baseline Assurance Jul 15	Update Sept 15	Responsibility	RAG
1.8 An infection prevention and control infrastructure should encompass: In acute healthcare settings for example, an ICT consisting of appropriate mix of both nursing and consultant medical expertise (with specialist training in infection control) and appropriate administrative and analytical support, including adequate information technology. The DIPC is a key member of the ICT		Awaiting implementation at Host Laboratory site prior to implementation at LWFT.	Awaiting implementation at Host Laboratory site prior to implementation at LWFT	Director of Nursing / Midwifery / Director of Infection Prevention and Control	Amber

14.2 Appendix C - Clinical Practice Audits NUMIS – Infection Prevention and Control audits

Clinical practice

All clinical practice audits (hand hygiene, sharps, PPE and 5 moments of hany hygiene audits) are entered locally onto the NUMIS system;this allows a real-time oversight of results.

Audits completed between , April 2016-March 2016 have been collated and the overall compliance for clinical practice audits have been updadted onto NUMIS.

Personal Protective Equipment	
Number of audits Due	42
Number of audits returned	41
Overall Compliance	98%
Completed audits scoring: <84% 85-94% 95-100%	0 (0 scores due to no return) 5 36
Themes of non-compliance :	Staff not always wearing eye protection

PPE Department Summary

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec15	Jan 16	Feb 16	Mar 16
TRUST OVERALL			99.2				95.27					
ANTENATAL CLINIC AINTREE			100				100					
ANTENATAL CLINIC LWH			98.66				100					
BEDFORD UNIT			100				100					
CLINICAL GENETICS			100				100					
DELIVERY SUITE			93.33				93.33					
EMERGENCY ROOM			100				100					
FETAL CENTRE			100				100					
GYNAE OUTPATIENTS LWH			100				100					
GYNAE OUTPATIENTS AINTREE			100				100					
GYNAE THEATRES			100				93.33					
GYNAE WARD / HDU			100				100					
HEWITT CENTRE			100				100					
IMAGING			100				0					
MATERNITY ASSESSMENT UNIT			100				100					
MATERNITY BASE			100				100					
MATERNITY THEATRES			100				93.33					
MIDWIFERY LED UNIT / JEFFCOATE WARD			100				100					
NEONATAL UNIT			100				100					
PHYSIOTHERAPY			100				100					
RMU KNUTSFORD			90				100					
ROSEMARY WARD / CATHARINE SUITE			100				100					

Sharps	
Number of audits due	40
Number of audits returned	39
Overall Compliance	98%
Completed audits scoring:<84% 85-94% 95-100%	0 (0 scores due to no return) 8 31
Themes of non-compliance:	Temporary closing of sharps bin not always used

SHARPS Department Summary

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec15	Jan 16	Feb 16	Mar 16
TRUST OVERALL	98.36						93.67					
ANTENATAL CLINIC AINTREE	100						100					
ANTENATAL CLINIC LWH	100						100					
BEDFORD UNIT	100						100					
CLINICAL GENETICS	90						95					
DELIVERY SUITE	100						96.15					
EMERGENCY ROOM	100						100					
FETAL CENTRE	100						100					
GYNAE OUTPATIENTS LWH	100						88					
GYNAE OUTPATIENTS AINTREE	100						100					
GYNAE WARD / HDU	100						96.15					
GYNAE THEATRES	100						90.90					
HEWITT CENTRE	100						96					
MATERNITY ASSESSMENT UNIT	100						100					
MATERNITY BASE	84.61						88.46					
MATERNITY THEATRES	100						90.90					
MIDWIFERY LED UNIT / JEFFCOATE WARD	96						100					
NEONATAL UNIT	95.65						90.47					
PHYSIOTHERAPY	100						100					
RMU KNUTSFORD	86.95						100					
ROSEMARY WARD / CATHARINE SUITE	100						0					

Hand Hygiene	
Number of audits due	44
Number of audits returned	43
Overall Compliance	98%
Completed audits scoring:<84% 85-94% 95-100%	1 (0 scores due to no return) 2 40
Themes of non-compliance:	All hand was sinks not free from inappropriate items. No hand cream.

Hand Hygiene Department Summary

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec15	Jan 16	Feb 16	Mar 16
TRUST OVERALL			98.73				95.11					
ANTENATAL CLINIC AINTREE			100				100					
ANTENATAL CLINIC LWH			100				100					
BEDFORD UNIT			100				100					
CLINICAL GENETICS			97.14				100					
DELIVERY SUITE			95				97.5					
EMERGENCY ROOM			100				100					
FETAL CENTRE			100				100					
GYNAE OUTPATIENTS LWH			100				100					
GYNAE OUTPATIENTS AINTREE			100				100					
GYNAE THEATRES			100				83.33					
GYNAE WARD / HDU			100				95					
IMAGING			97.05				94.59					
HEWITT CENTRE			100				100					
MATERNITY THEATRES			100				100					
MATERNITY ASSESEMENT UNIT			100				100					
MATERNITY BASE			94.87				97.43					
MIDWIFERY LED UNIT / JEFFCOATE WARD			92.30				100					
NEONATAL UNIT			97.14				98.26					
PHARMACY			100				100					
PHYSIOTHERAPY			100				100					
RMU KNUTSFORD			94.11				94.87					
ROSEMARY WARD / CATHARINE SUITE			100				0					

5 Moments (Monthly)	
Number of Audits Due	240
Number of Audits returned Overall Compliance	225 93%
Completed audits scoring:<84% 85-94% 95-100%	4 (0 scores due to no return) 20 201
Themes of non-compliance	Hand hygiene after low risk procedures.

5 Moments Department Summary

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec16	Jan 16	Feb 16	Mar 16
TRUST OVERALL	98.41	99.50	84.12	97.76	90.20	97.60	95.04	91.46	88.78	93.06	89.65	90
ANTENATAL CLINIC AINTREE	100	100	0	100	100	100	100	100	100	100	100	100
ANTENATAL CLINIC LWH	100	100	0	100	100	100	100	100	100	0	0	100
BEDFORD UNIT	100	100	100	100	100	100	100	0	100	100	100	0
CLINICAL GENETICS	100	100	100	100	100	100	0	100	100	100	100	100
DELIVERY SUITE	100	100	100	100	100	100	100	100	90	100	100	100
EMERGENCY ROOM	100	100	100	90	100	100	100	100	100	100	100	100
FETAL CENTRE	100	100	100	100	100	100	100	100	100	100	0	100
GYNAE OUTPATIENTS AINTREE	100	100	100	100	0	100	100	100	100	100	100	100
GYNAE OUTPATIENTS LWH	100	100	100	100	100	100	100	100	90	100	100	90
GYNAE THEATRES	90	100	100	100	100	100	100	100	100	100	100	100
GYNAE WARD / HDU	100	100	0	80	100	100	100	100	100	94.44	100	100
HEWITT CENTRE	100	100	100	100	100	100	100	100	100	100	100	90
IMAGING	100	100	100	100	90.90	100	100	0	100	90	100	100
MATERNITY ASSESSMENT UNIT	100	100	100	100	100	100	100	100	100	100	100	100
MATERNITY BASE	100	100	100	100	100	100	100	100	100	100	100	100
MATERNITY THEATRES	100	100	100	100	100	100	100	100	100	90	100	100
MIDWIFERY LED UNIT / JEFFCOATE WARD	100	100	100	100	100	70	90	100	0	100	100	100
NEONATAL UNIT	100	100	100	100	100	90	100	100	90	100	100	100
ROSEMARY WARD/CATHARINE SUITE	80	90	100	90	0	100	100	100	0	100	100	0
RMU KNUTSFORD	100	100	100	87.5	70	90	100	90	90	90	90	100

Actions

All audits are reviewed by the IPCT. Audits scoring less than 100% are to be actioned locally by clinical areas, the audit is only closed by IPCT once measures are in place or are audit has taken place.

Environmental Audits

The Environmental Audits were added to NUMIS in June 2015. There have been a number of minor updates to the NUMIS system since then;with an update to allow IPCT to forward a PDF copy of the environmental audit and actions to relevant staff e.g. Ward managers, Estates manager and G4S managers.

Environmental Audits	
Number of audits due	142
Number of audits returned	142
Audits scoring: <84% 85-94% 95-100%	19 51 72
Mean score % Ward environment Kitchen Linen Dept.Waste Patient Equipment	 89% 88% 93% 91% 96%
Themes of non-compliance:	High level dust Low level dust Items on floor Temporary closure on sharps boxes not always used correctly

14.3 Appendix D – MRSA Outbreak NICU

Summary

An outbreak of MRSA colonisation was identified in 2015-2016 involving 8 cases on the Neonatal Unit; one colonised baby subsequently became bacteraemic.

Key Timeline Points

13th July 2015 - The outbreak was recognised. Three babies identified with colonisation. A number of control measures were put in place.
28th July 2015 – 4th baby identified with colonisation. Cohort area established.
13th August - 5th baby identified with colonisation.

Control was achieved and from the end of August 2015 there was only one baby who remained colonised on the unit.

20th September 2015 -Unfortunately further spread occurred towards the end of September. Three additional babies had been identified with colonisation. Further enhanced surveillance was implemented along with additional environmental cleaning and monitoring.
1st October 2015 - Despite the actions put in place one of the newly colonised babies developed an MRSA bacteraemia. The baby was treated promptly with good effect and a PIR was undertaken.
22nd October 2015 - Two colonised babies remained on the unit and were nursed in cohort areas by dedicated nurses. Enhanced surveillance and enhanced use of personal protective equipment continued. Eye treatment room utilised as single barrier nurse facility.
8th December 2015 – Enhanced surveillance and additional barrier nursing discontinued. Final baby with MRSA discharged.

Actions

- The outbreak group met regularly to ensure agreed actions were implemented.
- Public Health England were updated frequently by the DIPC with all developments.
- Number of cots on the unit was reduced by 3
- Enhanced surveillance/screening implemented.
- Enhanced use of personal protective equipment.
- Barrier/cohort nursing implemented immediately.

Conclusion

- The outcome of bacteraemia PIR identified that infection was potentially preventable and that the source of the infection was likely to be line related.
- Audit data of compliance with infection prevention policies demonstrated good compliance and training records were up to date.

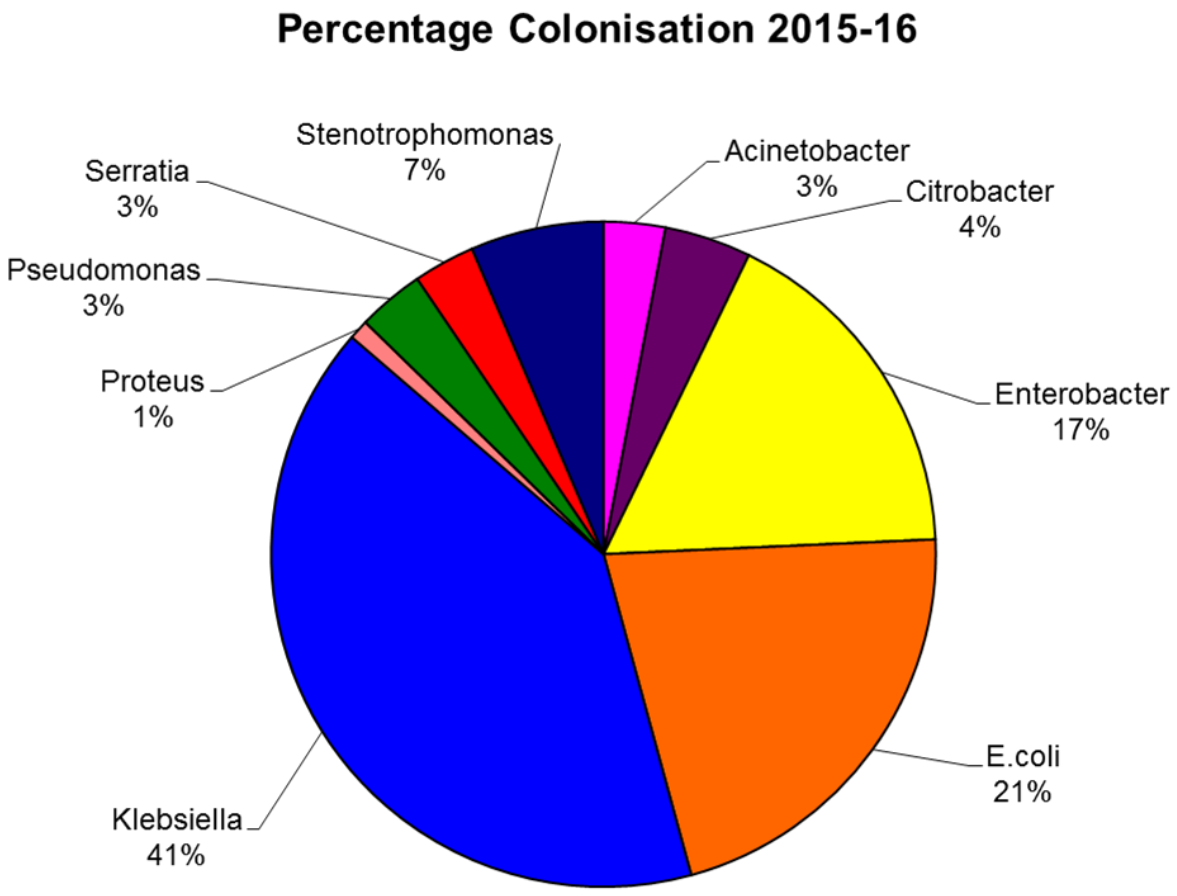
- Reviews of occupancy and staffing identified both high occupancy and acuity as potential contributing factors in the outbreak

Recommendations

- Plans for both increased staffing and modification to the estate to bring the unit in line with recommendations have been shared with National Commissioners.
- A review from CCG and PHE, report awaited.

14.4 Appendix E - Neonatal Colonisation Surveillance

	2005	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012-13	2013/14	2014/15	2015-16
Acinetobacter	1	1	1	1	1	2	1	3	3	6	3
Citrobacter	8	3	3	2	4	2	6	6	4	3	4
Enterobacter	17	19	15	12	16	15	21	21	17	14	17
E.coli	27	23	26	29	30	30	23	20	30	27	21
Klebsiella	34	29	34	32	33	31	38	32	34	39	41
Proteus	2	4	1	3	2	4	0	3	1	1	1
Pseudomonas	9	16	14	18	10	9	6	11	5	4	3
Serratia	1	3	4	1	3	4	2	2	2	1	3
Stenotrophomonas	1	2	2	2	1	3	3	2	4	4	7



14.5 Appendix F - Adult Bacteraemia Surveillance 2014 - 15

28 Positive blood cultures

7 Coagulase-negative staphylococcus or other contaminant.

21 Pathogens

Directorate	Organism	Potentially Hospital Associated	Likely Source
G*ynaecology*	E.coli	No	UTI
	E.coli	No	PID
	E.coli	No	Pelvis
	E.coli	No	UTI
	Klebsiella sp	Yes	Perforation
	S.aureus	No	Nephrostomy
	Bacteroides sp	No	Pelvis
Maternity	*E.coli*	No	Chorioamnionitis
	E.coli	Yes*	Pelvis
	E.coli	No	UTI
	E.coli	No	UTI
	E.coli	No	Chorioamnionitis
	E.coli	No	UTI
	H. Influenzae	No	Pelvis
	S.anginosus	No	Pelvis
	S.pneumoniae	No	Pneumonia
	K.pneumoniae	No	UTI
	Group B streptococcus	No	Peripartum
	Group B streptococcus	No	Peripartum
	Group B streptococcus	No	Peripartum
	Group B streptococcus	No	Pelvis

*RCA not undertaken

Agenda item no:	16/247

Meeting:	Board of Directors

Date:	7 October 2016

Title:	Patient Led Assessment of the Care Environment (PLACE) Assessment 2016

Report to be considered in public or private?	Public

Purpose - what question does this report seek to answer?	How did the Trust perform in the PLACE Assessment?

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

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

Which CQC fundamental standard/s does this report relate to?	Regulation 12 & 15: Safe Regulation 9&10 Caring Regulation 14: Effective

What action is required at this meeting?	The Board of Directors is asked to receive this report and note the content.

Presented by:	Director of Nursing and Midwifery/Patient Facilities Manager

Prepared by:	Linda Martin, Patient Facilities Manager

This report covers (tick all that apply):

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

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

PLACE – Patient **L**ed **A**ssessments of the **C**are **E**nvironment was introduced in April 2013.

The PLACE programme aims to promote the NHS Constitution principles and values by ensuring that the assessment focuses on the areas which patients say matter, and by encouraging and facilitating the involvement of patients, the public and other bodies with an interest in healthcare in assessing providers in equal partnership with NHS staff to both identify how they are currently performing against a range of criteria and to identify how services may be improved in the future.

It provides a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care.

Organisations are assessed in the following categories:

Cleanliness
Food (Organisation Food & Ward Food)
Privacy, Dignity and Wellbeing
Condition, appearance and maintenance
Dementia
Disability

The Trust PLACE Assessment was carried out on Wednesday 11th May 2016. The results were published nationally on 10th August 2016.

The following table details how the Trust 2016 results compare to the 2016 national results and to previous Trust's results since PLACE was introduced in 2013.

	Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition, Appearance and Maintenance	Dementia	Disability
Liverpool Women's 2016 results	**99.96%**	**89.79%** (Organisation 78.51% Ward food 94.95%)	**78.35%**	**94.90%**	**83.48%**	**78.15%**
National Average 2016 results	98.06%	88.24% (Organisation 87.01% Ward food 88.96%)	84.16%	93.37%	75.28%	78.84%
Liverpool Women's 2015 results	99.94%	92.55%	82.19%	93.31%	77.42%	
Liverpool Women's 2014 results	99.86%	89.28%	85.11%	96.51%		
Liverpool Women's 2013 results	97.91%	87.05%	96.03%	90.67%		

The Patient Facilities Manager managed the process which included a team of three patient representatives, three governors, volunteers, a matron, Housekeepers, Infection Control Nurse and Head of Patient Experience.

2. Issues for consideration

Cleanliness

99.96% The Trust scored above the national average and achieved its highest score since 2013.

Food (Organisation Food & Ward Food)

89.79% The Trust scored above the national average but lower than in 2015. In 2016 food scores were divided between organisation and ward – ward food scored higher than the national average and higher than previous years **(94.95%)** this indicates that the assessors were pleased with food provided to patients, including, choice, presentation, temperature, etc. on the day. However, it was the organisation score **(78.51%)** that brought the overall score down. Factors contributing to this were lack of audit in 2015/2016 based on malnutrition universal screening tool, timing of evening meal too early.

Privacy, Dignity and Wellbeing

78.35% The Trust scored lower than the national average and lower than in previous years. Factors contributing to this were introduction of wellbeing questions around availability of individual TV's, facility to have meals away from their beds if patients choose to do so, some reception desks do not provide sufficient distance away from others when discussing personal details.

Condition, appearance and maintenance

94.90% The Trust scored above the national average and improved its score from 2015

Dementia

83.48% This category was introduced in 2015. The Trust scored above the national average and improved its score from 2015

Disability

78.15% This is the first year this category has been included. The Trust scored slightly below the national average.

Other comments

Many positive comments were received on the day of the assessment which included:

"It is an important building which allows women to access an environment which treats their needs with dignity, confidentiality and specialist care"

"Food was good temperature – chef understood different foods (ethnic or religious requirements) so I was impressed"

"A pleasant hospital to visit. It is 20 years old and still in good state of repair"

"Patients satisfied with care given"

"Staff very pleasant"

Actions

Cleanliness	• Continue to monitor against National Cleaning Specifications. • Include results in Estates & Facilities quarterly reports to Infection Prevention & Control Committee. • Review at monthly Housekeepers' meetings
Food (Organisation Food & Ward Food)	• Later evening meal times being trialled in October – to report back to Nursing & Midwifery Board in November.
Privacy, Dignity and Wellbeing	• Individual TV provision is being addressed by the Nursing & Midwifery Board/SMT • Consideration to be given to improving reception areas and providing areas for patients to have their meals away from their beds, if and when any refurbishment takes place.
Condition, appearance and maintenance	• On going maintenance programme in place • Review monthly at Housekeepers' meetings • Address any issues highlighted in local environmental audits
Dementia	• Continue to work with Gynaecology directorate to further improve dementia friendly environment
Disability	• Formal disability access audit has been commissioned and completed – two red status actions identified, to be completed by end of October 2016. Other actions to be considered within 18 – 24 months, or when any refurbishment takes place.

3. Conclusion

Generally, mainly positive results and comments, with room for improvement if and when capital funding is made available.

Results will be published in all wards/clinics by end October 2016.

4. Recommendation/s

The Board of Directors is asked to receive this report and note the content.

Chair's Report from the Finance Performance and Business Development Committee held on 26 September 2016

16/249

Board of Directors

Committee Chair's report of Governance and Clinical Assurance Committee meeting held 16 September 2016

1. Agenda items covered

- Chair of the Committee would be Susan Milner, Non-Executive Director from 1 October 2016.
- EPPR Assurance: the Committee was action to review responses to questions raised by the Board at its meeting on 2 September 2016 with regard to the 2016/17 Emergency Preparedness, Resilience and Response (EPRR) Assurance report. The Committee reviewed the responses and were satisfied that processes were in place to address the concerns identified by the Board. The Committee requested that the action plan is brought back to GACA in November 2016 and reported to the Board in December 2016.
- Overview of Still Births: The Committee received a report on the Trust's still birth rates and received assurance that benchmarking against peer trusts takes place. They also received assurances that processes were in place to identify cases which require further review.
- Safeguarding Annual Report: the Committee received the safeguarding annual report and recommended it to the Board for approval
- Update on Action Plan arising from the Francis Report: The Committee noted that most of the actions had been completed; however there were 4 outstanding actions which needed to be completed, two of which related to IT. It was agreed that these would be escalated to the FPBD Committee for review at the meeting in October and report back to GACA in November. The committee received reports that the other two risks, Council of Governors engagement with the public statement and prescribing of medicines would be completed following publication of the membership and public engagement strategy and the implementation of an update to Meditech system.
- Clinical Assurance and Performance: the Committee have asked that a set of quality standards for 2017/18 be brought back to the Committee for review in January 2017 before going to the Board for final sign off. The Associate Director of Operations suggested further work to align Performance metrics with the SEE Report.
- Information Governance Update: the Committee noted that there Trust was not achieving the requirement for 95% of staff to complete IG mandatory training and this was to be escalated to PPF to review.
- Review of Action Plan from June 2016 Compliance Inspections and December 2016 Compliance Inspections: The Trust is committed to run mock inspections and in June a mock inspection identified a number of actions. The Committee was assured that the action plan was on target and would be completed by the end of December 2016 with one completed by March 2017. A further mock inspection would be completed in December as reported in the September CEO report to the Board. The Committee received an update on the process that would be undertaken.
- Assignment of Trust Leads for the CQC Fundamental Standards: Establishment of Trust Leads for the CQC Fundamental Standards was discussed. Further work was required on the role of the designated NED for each standard.

2. Board Assurance Framework (BAF) risks reviewed

- The Committee agreed to de-escalate Risk 1735 (1e on the BAF). They noted that there was a robust system in place for managing alerts, overseen by the Safety Senate. It was therefore agreed that this risk be de-escalated and managed locally on the Governance Risk register.

- The Committee was informed by the Associate Director of Operations that the Neonatal Transport Service does not have enough Junior Doctors to cover the rota. The Committee therefore agreed to a new risk being added to the BAF after discussion at the Neonatal MDT. This is new Risk 1o on the BAF.

3. Issues to highlight to Board

- Neonatal Risk on the BAF.

4. BAF recommendations

The Board is asked to note the changes to the BAF as set out above and in the BAF paper to the Board.

5. Action required by Board

- The Committee recommends the Safeguarding Annual Report 2016 for approval
- The Committee recommends the changes to the Terms of Reference for Board approval, noting that the reporting committee 'Corporate Risk Committee' may move to report to the FPBD Committee.
- Approve changes to the BAF (see BAF paper to the Board)

Attached Terms of Reference for approval

GOVERNANCE AND CLINICAL ASSURANCE COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Governance and Clinical Assurance Committee (GACA) (the Committee).
Duties:	The Committee is responsible for: • Receiving assurance that the Trust has in place effective integrated governance systems, risk management and quality improvement • Exercising oversight of the systems of governance, risk management and quality improvement and focusing on matters of concern • Seeking and providing assurance to the Board that the Trust's systems of governance and risk management are fit for purpose, adequately resourced and effective deployed in order to achieve organisational objectives • Seeking assurance that the Trust complies with its own policies and all relevant external regulation and standards of governance and risk management • Oversight, scrutiny and monitoring of progress against the Trust Quality Strategy. In particular the Committee will be responsible for: a) Reviewing risks included on the Board Assurance Framework that are assigned for its oversight b) Receiving assurances in respect of the Trust's quality performance. These assurances will come from internal and external sources including (but not limited to): • The Trust's Safe Effective Experience Report (SEE) • Exception reports from internal Provider Compliance Assessment against CQC Fundamental Standards and other regulatory frameworks • Patient surveys • The Director of Infection Prevention and Control • Chairs reports and items for escalation of subordinate committees • Review of morbidity and mortality

	• Assurance reports relating to quality improvement initiative eg SU2S, and other QI projects commissioned locally by the Trust and by divisions • Opportunity to review harm free care data which currently is not considered anywhere c) Testing assurances through 'deep dives' as require, including Quality quarterly review of clinical services d) Receiving exception reports in respect of matters of non-compliance with clinical quality, performance and risk management targets and standards e) Reviewing the Trust's draft quality report and recommending it to the Board of Directors f) Receiving assurances in respect of progress against the Trust's quality report g) Receiving assurance in respect of the Trust's response to national clinical guidance from external agencies such as the Care Quality Commission, Health and Safety Executive h) Receiving the quarterly Board Statements relating to quality and governance as submitted to Monitor i) Reviewing the Trust's draft Research and Development strategy and recommending it to the Board of Directors j) Receiving assurances in respect of progress against the Trust's Research and Development strategy k) Approval of the Trust's Patient Experience Strategy and recommending it to the Board of Directors l) Receiving assurances in respect of progress against the Trust's Patient Experience Strategy m) Receiving assurances in respect of the Trust's clinical audit function n) Approving the terms of reference and memberships of its subordinate committees o) Considering relevant matters delegated or referred to it by the Board of Directors or referred by any of the Board Committees p) Referring relevant matters for consideration to other Board Committees as appropriate. q) Escalating matters as appropriate to the Board of Directors.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of:

	• Non-Executive Director (Chair) • Two additional Non-Executive Directors (one of whom shall be Vice Chair) • *Medical Director • *Director of Nursing and Midwifery • *Director of Finance • *Director of Workforce and Marketing • *Committee Chairs of the Safe, Experience and Effectiveness Senates • Deputy Director of Nursing and Midwifery *or their nominated representative who will be sufficiently senior and have the authority to make decisions Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee and another Non-Executive member to be Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent.
Quorum:	A quorum shall be three members including two Non-Executive Directors and one Executive Director (one of whom must be the Medical Director or the Director of Nursing and Midwifery). The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a. Members Members will be required to attend a minimum of 75% of all meetings. b. Officers

	The Head of Governance and Trust Secretary shall normally attend meetings. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held bi-monthly, with at least 5 meetings per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It will report directly to the Board of Directors in respect of matters of risk excluding financial and commercial risks which are within the remit of the Finance, Performance and Business Development Committee. The Committee is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Governance and Clinical Assurance Committee will be accountable to the Board of Directors. The minutes of the Governance and Clinical Assurance Committee meetings will be formally recorded and submitted to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to it, or require executive

	action. Approved minutes will also be circulated to members of the Audit Committee. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Governance and Clinical Assurance Committee.
Reporting Committees/Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report and minutes of meetings; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Safety Senet • Effectiveness Senet • Experience Senet • Hospital Safeguarding Board • Health and Safety Committee • Infection Prevention and Control Committee
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Governance and Clinical Assurance:	16 September 2016
Approved by Board of Directors:	7 October 2016 (TBC)
Review date:	September 2017

Document owner:	Colin Reid, Trust Secretary Email: colin.reid@lwh.nhs.uk Tel: 0151 702 4033

16/250

Board of Directors

Committee Chair's report of PPF Committee meeting held 23 September 2016

1. Agenda items covered

- Staff Story – Gynae Nurse Practitioner – A member of staff shared her personal story of work related stress, describing the missed opportunities to support her early on, the positive experience and support she received from colleagues, occupational health, and senior managers when she became so ill she could not attend work. Learning opportunities had been identified and shared, and those who could have intervened earlier had received constructive personal feedback.

- Hewitt Fertility Service Workforce Review – a deep dive into the workforce risks, challenges, mitigation and longer term plans to address those risks

- Medical Education Update – Paper providing assurance that all training & education of medical students and doctors meets the new GMC requirements

- Apprenticeship Levy – Updating the Committee on the £300k Apprenticeship Levy, its challenges and opportunities and providing assurance that the Trust was clear about the steps it would be taking to meet the Apprenticeship target of 31 wte

- Leadership Development - The new Leadership Development programme was described, providing assurance of its links to best practice and response to Trust's challenges

- Review of Transactional HR Service – 12 monthly review of the effectiveness of the in house transactional service demonstrated effective working practices, supporting service delivery.

- WRES Update – The Committee approved the Action Plan developed by the Diversity & Inclusion Committee to support improvements relating to the Workforce Race Equality Scheme

- HR KPIs – Monthly KPIs reviewed. Increased focus on turnover, recognizing increasing turnover in corporate areas potentially associated with Future Generations Strategy. Committee recognized this as a risk associated with the proposed change. Retention strategy developed for key posts.

- Staff Engagement/Pulse – Effectiveness of PULSE survey (Staff Friends & Family Test) questioned. Committee recommended a review of staff engagement strategies and the process for gathering staff Friends & Family data.

- Review of Payroll Provision – Committee assured of robust payroll arrangements and noted the extension of current contract with other NHS provider pending commencement of tendering process

- Medical Appraisal & Revalidation Annual Report – Committee assured of the Trust's successful implementation of doctors appraisal and revalidation, noting external audit assurance. Committee approved the Statement of Compliance.

- Policy Approval – the following policies were ratified

    - Personal Use of Social & Attributed Media Policy
    - Redeployment Policy
    - Organisational Change Policy
    - Flexible Working Policy
    - Secondment & Acting Up Policy
    - Maternity, Paternity & Adoption Leave Policy
    - Recruitment & Selection Policy
    - Whistleblowing Policy
    - Annual Leave for Medical Staff
    - Clinical Excellence Awards Policy
    - Senior Medical Staff covering Junior Medical Staff (out of hours) Policy

Board Assurance Framework (BAF) risks reviewed

- All Committee relevant BAF risks were reviewed and no amendments recommended.

- The committee identified a theme with respect to shortage of junior medical staff which was impacting on rotas across clinical services. Risk to date captured within service risk registers and at corporate risk level but Committee felt now merited a review of total risk by GACA

2. Issues to highlight to Board

- Age profile of nursing workforce within Hewitt identified as a potential risk to service delivery but good mitigation and actions to address in place

- Apprenticeship Levy equating to £300k top-sliced and held nationally, can only be drawn down to support training costs (not salary or backfill) and requirements to meet public sector duty of 31 wte Apprenticeships in 2017/18.

- Turnover demonstrating an increasing trend particularly in corporate services. Actions to monitor and address where possible through shared appointments/services. Clinical services not experiencing difficulty in recruiting (other than in known shortage areas)

- Confident that we provide a good medical educational experience across all levels and have robust action plans to address areas identified for improvement.

3. Action required by Board

To receive the report of the Putting People First Committee.

Chair report provided by:
Tony Okotie
Date: 1 October 2016

Liverpool Women's NHS Foundation Trust

Putting People First Committee Annual Report 2015/16

Putting People First Committee

The aim of the Human Resources and Organisational Development Committee is to develop and oversee the implementation of the Trust's People Strategy (integrated workforce and organisational development strategy – One Team, One Goal: Putting People First) providing assurance to the Board of Directors that this is achieving the outcomes sought and required by the organisation. The terms of Reference of the Committee were reviewed in April 2015 and are as follows

In discharging these duties the Committee is responsible for:

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

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

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

Constitution

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

- Non-Executive Director (Chair)
- 1 other Non-Executive Director
- Director of Workforce & Marketing
- Director of Nursing & Midwifery
- Associate Director of Operations
- Staff Side Chair
- Medical Staff Committee representative
- Matron

In addition the Committee was supported by the following officers, Senior HR Business Partners, Chair of Education Governance Committee, the Head of Midwifery, the Head of Nursing with other officers attending as required.

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

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

Four meetings were held during the financial year 2015/16 .

Minutes of the Putting People First Committee are presented to the Board of Directors in addition to the Chairs written report.

Achievements

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

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

In 2015/16, the Committee

- Agreed its Risk Appetite Statement for relevant risks
- Undertook a deep dive and gained assurance with respect to workforce risks in the following clinical service areas

    - Maternity,
    - Genetics
    - Hewitt Fertility
    - Gynaecology
- Maintained a line of sight on all workforce related Key Performance Indicators
- Gained assurance that robust processes were in place to maintain safe service delivery during periods of junior doctor industrial action
- Gained assurance around the processes to deliver and monitor compliance with mandatory training requirements
- Considered the Annual Staff Survey results and were pleased to note the continued improvement in overall staff engagement
- Gained assurance that appropriate controls were in place with respect to the Lampard recommendations and supported a proposal to introduce three yearly DBS checks for relevant staff and a strengthening of the temporary workers policy
- Gained assurance that there were no trends of concern with respect to the Trust's Disciplinary and Grievance processes
- Undertaken a workshop to inform the development of the Whistleblowing policy and actions to support staff to raise concerns
- Regularly reviewed progress against the Deloittes and CQC Action Plans
- Gained assurance that appropriate progress was being made in line with the Health & Wellbeing Strategy
- Regularly reviewed the progress made against the Equality Delivery System Goals and selected the areas for focus for improvement for 2015/16
- Learned about the introduction of the Workforce Race Equality Standard (WRES), identified the areas for improvement within the Trust and remitted the actions to the Diversity & Inclusion Committee
- Received the Workforce Profile Report and identified areas for further action with specific regard to the employment of those with a disability
- Were assured by six monthly and annual reviews of the Putting People First Strategy which demonstrated progress being made in accordance with the objectives of the Strategy
- Were assured that mandatory requirements with respect to the introduction of the Care Certificate
- Reviewed the findings of the Job Plan Audit and the actions required to provide greater assurance
- Were assured by the green rating for the Audit of Payroll services
- Welcomed the appointment of a Freedom to Speak Up Guardian
- Were assured that technical issues with PULSE had been resolved and welcomed the relaunch of the PULSE Engagement tool and reviewed the response rates for the Staff Friends & Familiy Test for the year to date
- Were assured that robust arrangements were in place for Nurse & Midwfery revalidation
- Were advised of the requirements of the new GMC Educational Standards and were assured by the actions and progress made to ensure compliance
- Endorsed the organisation signing up to the Mindful Employer Charter
- Were advised of the proposed introduction of the Apprenticeship Levy and the implications for the Trust

- confrimed that no Settlement Agreements had been entered into during the year

The Committee also reviewed and approved the following policies & Standard Operating Procedures:-

- Professional Registration & Revalidation
- Attendance Management
- Time to Undertake Trade Union Duties
- Equality Impact Assessments
- Job Planning for Consultant Medical Staff
- Job Planning for SAS Medical Staff
- Junior Doctors Monitoring
- Recruitment & Selection
- Alcohol & Substance Misuse
- Redeployment
- Secondary Employment
- Retirement
- Expenses
- Clinical Excellence Awards
- Removal Expenses
- Study & Professional Leave
- Disciplinary
- Work Experience
- Overpayment, Underpayments & incorrect Payments
- Annual Leave for Medical Staff
- Removal & Related Expenses for Consultant Medical Staff
- Volunteers
- Transgender
- Annual Leave
- Grievance
- Job Matching & Evaluation
- Maternity & Adoption
- Organisational Change, Pay Protection & Redundancy
- Whistleblowing
- Senior Medical Staff covering Junior Medical Staff (Out of Hours)
- ESR & Establishment Control

The Committee received minutes from the following reporting Committees:

Partnership Forum
Education Governance Committee
Equality & Human Rights Committee (now Diversity & Inclusion Committee)
Nursing & Midwifery Board

Moving Forward in 2016/17

In 2016/17 the Committee will

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

Analyse trend data arising from the monthly KPI data on an annual basis.

Seek to align further align with other Board Assurance Committees to provide cross-Committee dissemination of information and assurance.

The Committee will continue to meet at least four times per year with additional meetings will be arranged if necessary (which will be kept under review). The main functions of the Committee remain the same as the previous year in:

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

2) Overseeing implementation of the Putting People First: Engaging for Excellence integrated workforce and OD strategy.

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

Putting People First Committee Chair
June 2016

Agenda Item No:	16/251
Meeting:	Trust Board
Date:	07 October 2016
Title:	Performance Dashboard - Month 5 - August 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**	X

Which Board Assurance Framework risk(s) does this report relate to?	1. Deliver safe services 3. Deliver the best possible experience for patients and staff 4. To develop a well led, capable and motivated workforce 5 to be ambitious and efficient and make best use of available resources
Which CQC fundamental standard(s) does this report ralet to?	Reg 17 Good Governance Reg 18: Staffing Reg 12 Safety Reg 16 Complaints
What action is required at this meeting?	To Note
Presented by:	Jeff Johnson
Prepared by:	David Walliker

This report covers (tick all that apply):

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

Other:

Monitor Compliance	✓		Equality and diversity	
NHS Constitution			Integrated business plan	

Publication of this report (tick one):

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

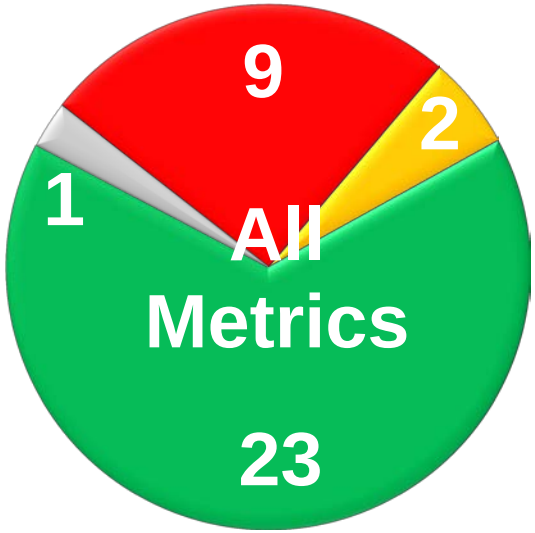
1. Introduction and summary

2. Issues for consideration

3. Conclusion

4. Recommendation/s

Performance Report - Trust Board — Month 5 - August 2016



Performance Summary - Trust Board - Month 5 - August 2016

Overview

Of the 35 KPI's reported in the Trust Board Dashboard for August 2016, **23** are rated Green, **9** are rated Red and **2** are rated as Amber. The figure for Choose and Book is not yet available nationally.

The KPI's rated as Red are:

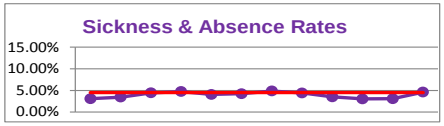
- HR: Sickness & Absence rates have breached the 4.5% target at 4.6% for the first time this fiscal year.
- HR:Staff Turnover rates have continue to increase at 16% against a target of <= 10%, is the highest rate this fiscal year.
- Maternity: Triage within 30 Minutes, although improving at 91.66%, has breached fthe >= 95% target for the 6th consecutive month.
- Maternity: Women not given an Epidural for non-clinical reasons , although improved, at 5.45% has breached the <=5% target for the 3rd consecutive month.
- 6 Week Diagnostic Waits have breached the >= 99% target at 97%. This target has been achived once this fiscal year.

The KPIs rated as Amber are:

- HR: Mandatory Training rates has fallen slightly to 93% against a target of >= 95%
- Last minute cancellations for non-clinical reasons, although improved, at 4.8% has breached the <= 4% target rate for the 4the consecutive month.

Performance Summary - Trust Board - Month 5 - August 2016

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

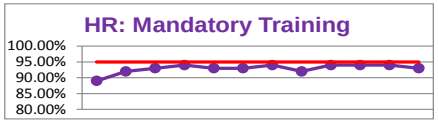


HR: Sickness and Absence Rates at 4.6% against a target of <= 4.5%

All the large clinical areas saw significant increases in the level of sickness absence in month five. The proportion of short term sickness increased from 23% of the overall total in month four, to 35% of the overall total in month five.

Linked to the above, 'anxiety/stress/depression' is still the top diagnosis in the Trust, followed by 'other musculoskeletal problems' and 'back problems'.

Managers continue to 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.

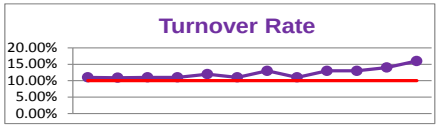


HR: Mandatory Training Rate at 93% against a target of >= 95%

There were few significant changes at service level with most figures staying the same or going up or down by one or two per-cent. The only exceptions to this were Medical Staff – down three per-cent from 92% to 89%. Pharmacy – down six per-cent from 83% to 77%

There are currently ten areas rated as green as they are above the Trust target figure of 95%. Five are as rated as amber: Gynaecology, Maternity, Medical Staff, Surgical Services and Trust Offices. Two are rated as red: Pharmacy and Transport.

All efforts are ongoing to reach the overall mandatory training target of 95%, it is anticipated the target will be reached by the end of quarter three.



HR: Staff Turnover Rate at 16% against a target of <= 10%

In August 2016, YTD turnover was 16% for the Trust overall and 23% for Corporate areas, against a target of 10%. There has been an increased trend in HR, Finance, Estates and Trust offices. Three senior managers have left the Trust in the last 6 months, which are likely to present some challenges in terms of recruitment. The retention strategy was designed to increase retention in these posts and hence may need to be revisited. Partnership working with other Trusts is being explored in the short term, in IT and Finance roles. In the clinical areas, turnover has increased in Gynaecology from 8% to 19% the previous year but this is spread across all departments and no concerns have been identified. Turnover remains stable in the other clinical areas including maternity. Where there are long term issues with recruitment and retention such as Genetics, Theatre Nursing and Neonatal Nursing, ongoing recruitment and retention strategies have been implemented.

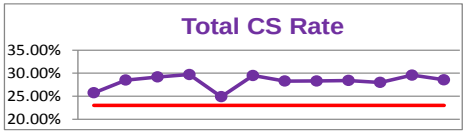
All Linear graphs are rolling 12 months

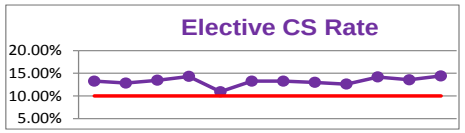
Performance Summary - Trust Board - Month 5 - August 2016

To be EFFICIENT and make best use of available resources

Financial Report will be provided separately (2 x Red KPIs)

To deliver SAFER services





Total Caesarean Section Rate at 29.59% (Target <= 28%)

and

Elective Caesarean Section Rate at 13.57% (Target <= 10%)

The Target and rates of Caesarean sections have been reviewed along with benchmarking of rates in other Trusts and within the CWest Coast Strategic Clinical Network. This work has informed our target rates and the findings of the review will be presented for clinical review at the next GACA meeting. Once they are signed off at GACA, the new target rates will be incorporated into the Performance Report Framework for September. In the mean time, the rates will continue to be closely monitored.

All Linear graphs are rolling 12 months

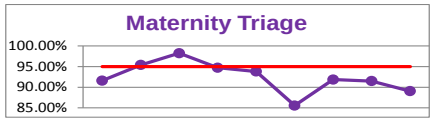
Performance Summary - Trust Board - Month 5 - August 2016

To deliver the most EFFECTIVE outcomes

There are no Red or Amber rated KPIs in this section

Performance Summary - Trust Board - Month 5 - August 2016

To deliver the best possible EXPERIENCE for patients and staff



Rate of epidurals not given due to non-clinical reasons at 5.45% against a target of <= 5%

Of the 143 Epidurals requested (excluding those not given due to clinical reasons) 9 were not provided due to non-clinical reasons. Two weren't given due to an aesthetist not being available and 7 weren't given due to the acuity levels on Delivery Suite.

Shift leaders continuously monitor the availability of of epidurals to try ensure that women whom ask for an epidural receive one.

Rate of women Triaged within 30 minutes at 91.66% against a target of >= 95%

Increased summer activity levels and vacant posts have contributed to the failure to achive this performance target.

However sickness & absence continues to be appropriately managed by the midwifery management team and actioned in line with local policy. Annual leave requests are managed by the midwifery management team and allocated accordingly

Two newly appointed Consultant have commenced in post ,this will increase the senior level of visibility and clinical skills within the MAU, leading to improved timely assessment of women .

Some new midwives have commenced in post a number are still awaiting there registration number, once this is obtained they will be formally added to the midwifery workforce

Any breaches are escalated to the 104 bleep holder, to see if staff can be redeployed in times of increased activity to try to achieve the target.

A band 7 shift leaders has been present on all shifts in the MAU for over a month now this is to offer clear clinical leadership, ensure women are appropriately risk assessed and that the escalation process is activated if required.

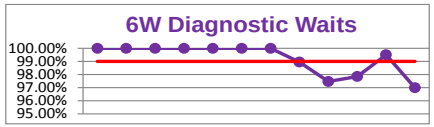
Women who contact triage with a clear history of established labour with regular uterine contractions are now asked to attend either the MLU or the DS as appropriate. This needs to be monitored closely to ensure compliance.

Work is ongoing with head of operations and performance / IT in relation to maternity capacity and demand and the requirements for inpatient beds. The maternity operational plan has highlighted the need for additional bed capacity.

Some work streams will be ongoing as the current process need a review to identify those times when the target is not achieved to see what barriers prevent us achieving this as there is one single cause which can make it more complex to control however it is expected that the target will be achieved by the end of October 2016.

As performance against these two KPIs has continued to breach their respective targets, the Executive Team have requested a full report by the 29th September 2016. In addition Ward managers have been asked to provide daily breach reports containing an analysis of each patient that has breached. Service managers will be invited to present their progress reports at SMT on a weekly basis until such a time as the Board is assured that performance against these two KPIs has progressed and targets have been consistently achieved.

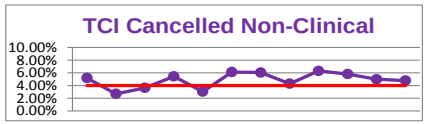
Performance Summary - Trust Board - Month 5 - August 2016



6 Week Diagnostic Waits at 97% against a target of >=99%

The target was breached in August 2016 due to a lack of capacity in performing Cystometeries. Although planned annual leave was accounted for, another consultant left the Trust at this time, therefore capacity was reduced further.

A replacement consultant has been appointed and there is an ongoing review of cystometery patients being booked to ensure they are being booked in the correct wait order. It is expected that the target rate should be achieved early in quarter 3.



Cancelled TCI: Non-clinical reasons at 4.8% against a target of <= 4%

Although still breaching the 4% target, performance against this KPI has been steadily improving since April. Currently the patterns show that the majority of non-clinical cancellations are due to list changes where more urgent cases have taken priority. or where cases have been brought forward.

Where previously cancellation reasons were not being recorded ror individual patients on Meditech, this is now happening and it will be possible to perform a thematic review of the cancellations from September onwards. This should enable us to clearly identify any process issues that may or may not be contributing to the rate of non-clinical cancellations.

Emerging Concerns

Of emerging concern from August is that performance against the 18 Week RTT Incomplete Pathways has decreased to just over the 92% target threshold at 92.6%. The issues are within the Genetics specialty where performance is at 81.8%. Action has already been undertaken with an increase in capacity of a 1000 additional appointments over the next year. An additional consultant will begin work in January 2017, in the meantime there is a locum Consultant in post to reduce the waiting times. Furthermore, the waiting list has been reviewed and re-trieged with cases being moved from the Medical side into the Counselling side. The service have a business case with Specialist Commissioners detialing the need for a futher additional consultant. The Family History Team, if approved, will further increase capacity rthrough reducing the need for the majority of follow-up cases.

A&E Unplanned re-attendances has breached the target for 3 out of the last 5 months. Thematic analysis is underway. This is currently reported to FPBD and to GACA.

SI Actions that remain outstanding. This has been excalated to the Medical Director who is managing it through the Safety Senate in October 2016.

Conclusion

Overall, for August 2016 the Trust performance has the same consistent themes that will be raised with the Service Managers and Clinical Leads. They will also be addressed at the Quarterly Review with Executives and Services in October 2016.

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							
HR: Sickness & Absence Rates (Commissioner)		<= 4.5%	4.42%	3.51%	3.05%	3.09%	4.61%							
HR: Annual Appraisal and PDR		>= 90%	89.00%	87.00%	82.00%	87.00%	90.00%							
HR: Completion of Mandatory Training		>= 95%	92.00%	94.00%	94.00%	94.00%	93.00%							
HR: Turnover Rate		<= 10%	11.00%	13.00%	13.00%	14.00%	16.00%							

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

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
Total Caesarean Section Rate		< 23%	28.29%	28.41%	28.00%	29.59%	28.57%							
Elective Caesarean Section Rate		< 10%	13.00%	12.61%	14.17%	13.57%	14.42%							
Safer Staffing Levels (Overall - includes Registered and Care Staff)		<= 90%	92.78%	91.92%	92.60%	91.70%	86.86%							
Serious Incidents: Number of Open SI's		Monitoring Only	22	21	18	18	17							
Serious Incidents: Number of New SI's		Monitoring Only	1	2	4	2	2							
% of women seen by a midwife within 12 weeks		>= 90%	96.82%	95.44%	95.70%	94.88%	91.78%							
Neonatal Bloodstream Infection Rate		TBD	0.11	0.00	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							
Biochemical Pregnancy Rates		> 30% TBC	45.94%	47.62%	46.21%	44.70%	47.13%							
Still Birth Rate (excludes late transfers)		TBD	0.00	0.01	0.01	0.01	0.00							
Neonatal Deaths (all live births within 28 days)		Rate per 1000 TBD	1.44	2.90	6.65	1.33	0.00							
Returns to Theatre		<= 0.7% TBC	0.64%	1.03%	0.50%	0.51%	0.22%							

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%							
Number of Complaints received		<= 15	15	5	13	18	13							
18 Week RTT Incompletes (aggregate)		>= 92%	95.71%	95.90%	93.86%	95.20%	94.28%							
Friends & Family Test		> 75%	99.26%	98.47%	98.60%	97.52%	100.00%							
% 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%							
% Women given one to one care whilst in established Labour (4cm dilation)		>= 95%	96.86%	96.08%	94.44%	95.74%	95.60%							
6 Week Wait Diagnostic Tests		>= 99%	98.96%	97%	98%	100%	97%							
Last Minute Cancellation for non-clinical reasons		<= 4%	4.30%	6.31%	5.81%	5.01%	4.79%							
Last Minute Cancellation for non-clinical reasons (Not re-admitted within 28 days)		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%	Not Avialable	Not Avialable							

Agenda item no:	16/252

Meeting:	Board of Directors

Date:	7 October 2016

Title:	Month 5 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 Single Oversight Framework NHSI September 2016

Resource impact:	-

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

Which Board Assurance Framework risk/s does this report relate to?	5a

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

What action is required at this meeting?	To note the Month 5 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	

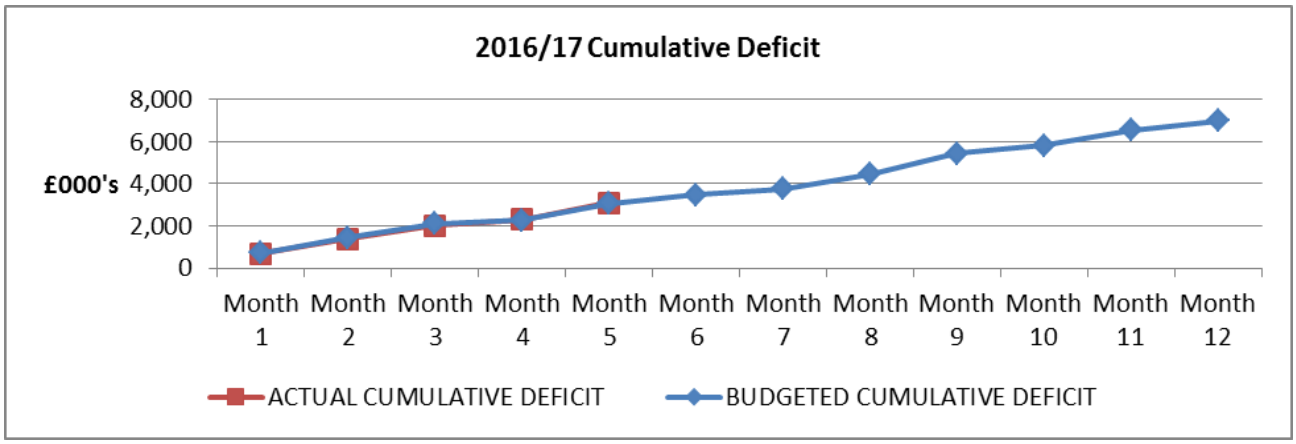
1. Executive Summary

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 of 2 and a cash shortfall of £7.7m. This planned position assumes receipt in full of £2.8m Sustainability and Transformation Funding.

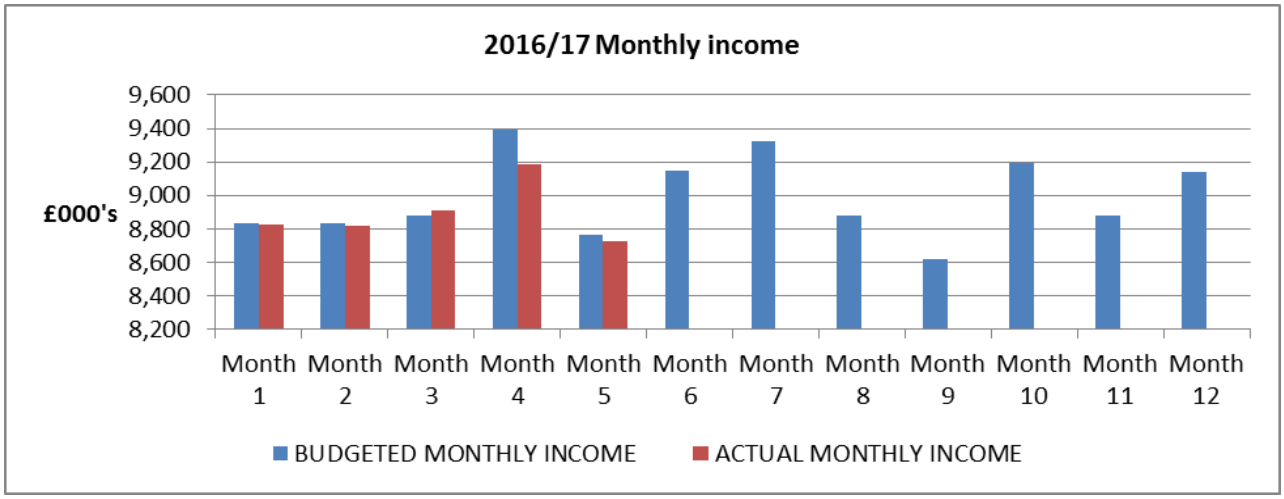
In Month 5 the Trust is reporting a monthly deficit of £0.801m against a deficit plan of £0.786 which is a negative variance of £0.015m for the month. Cumulatively the Trust is behind plan by £0.030m. The Trust achieved a Financial Sustainability Risk Rating (FSRR) of 2 against a plan of 2.

Following further detailed review in Month 5, the Trust is still forecasting to achieve the overall control total of £7m deficit for the full year, although there are some areas of over and under-performance within that total and issues to be addressed in order to ensure delivery of the anticipated control total in 2017/18.

2. Summary Financial Position



Total income in month was slightly lower than plan (see below).While maternity and gynaecology continued to over-perform, some other services did not achieve target. These are discussed in Section 3



Pay expenditure remains below budget predominantly due to non-recurrent vacancies across a number of services including neonates, Hewitt Centre, Catherine Medical and genetics. With the

exception of neonates the vacancies are reflective of controls over staffing in relation to lower than planned levels of activity in those services.

Whilst largely on track in month, non-pay expenditure is forecast to be above plan predominantly due to the non-delivery of CIP in gynaecology/theatres.

The FSRR components are set out below.

FINANCIAL SUSTAINABILITY RISK RATING	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR Budget	YEAR FOT
CAPITAL SERVICING CAPACITY (CSC)				
(a) EBITDA + Interest Receivable	(318)	(429)	(400)	(648)
(b) PDC + Interest Payable + Loans Repaid	875	808	2,712	2,547
CSC Ratio = (a) / (b)	**(0.36)**	**(0.53)**	**(0.15)**	**(0.25)**
MONITOR CSC SCORE	1	1	1	1
Ratio Score **4** = 2.5 **3** = 1.75 **2** = 1.25 **1** < 1.25				
LIQUIDITY				
(a) Cash for Liquidity Purposes	(3,488)	(5,128)	(8,924)	(8,924)
(b) Expenditure	45,035	44,908	108,297	107,870
(c) Daily Expenditure	300	299	301	300
Liquidity Ratio = (a) / (c)	**(11.6)**	**(17.1)**	**(29.7)**	**(29.8)**
MONITOR LIQUIDITY SCORE	2	1	1	1
Ratio Score **4** = 0 **3** = -7 **2** = -14 **1** < -14				
I&E MARGIN				
Deficit	3,068	3,098	7,000	7,000
Total Income	(44,713)	(44,471)	(107,887)	(107,210)
I&E Margin	**-6.86%**	**-6.97%**	**-6.49%**	**-6.53%**
MONITOR I&E MARGIN SCORE	1	1	1	1
Ratio Score **4** = 1% **3** = 0% **2** = -1% **1** < -1%				
I&E MARGIN VARIANCE				
I&E Margin	-6.86%	-6.97%	-6.49%	-6.53%
I&E Variance Margin	**0.83%**	**-0.11%**	**0.83%**	**-0.04%**
MONITOR I&E MARGIN VARIANCE SCORE	4	3	4	4
Ratio Score **4** = 0% **3** = -1% **2** = -2% **1** < -2%				
Overall Financial Sustainability Risk Rating	2	2	2	2

3. Service Review

The key components of the Month 5 financial position are outlined below. (See appendix 1 for detailed results)

Maternity
Income across maternity is ahead of plan in month, year to date and is forecast to be £0.629m ahead by the end of the year. Deliveries continue to outperform the plan by c7%.

There has been minimal increase in costs to date to deliver the additional activity. Overall it is forecast that Maternity will deliver a net favourable result in the region of £0.163m.

Gynaecology and Theatres
Gynaecology has seen strong activity performance across general services since the start of the year. In Month 5 this continued to perform above plan. Ongoing underperformance across oncology has continued, however income overall remains £0.383m ahead of plan at Month 5 and is expected to continue to over-perform for the remainder of the year.

The outperformance in activity is currently supporting the non-delivery of the theatres efficiency CIP (full year target £0.5m). Recovery plans are in place in relation to the delivery of the CIP scheme and mitigation is in place to compensate for the shortfall arising from the delay in the scheme.

Neonatal
The majority of neonatal income is on block contract and as such is not directly impacted by activity on a month by month basis. However, income from Welsh and other out of area commissioners is on a cost by case basis and the unit has seen a reduction in the amount of those babies it has treated. This equates to the majority of the income shortfall by Month 5. This is as a result of the neonatal cots being fully utilised for Cheshire and Merseyside activity. NHS England have been informed of the financial impact of this and approached to support the shortfall.

The income shortfall is being somewhat offset by non-recurrent underspend across pay which has arisen through vacancies. This will however become problematic in 2016/17 when the vacancies are fully recruited to. The financial burden of training neonatal nurses and ANNPs has been flagged to NHS England who recognise that LWH invest significant resource into trainees in order to future-proof the service. It was agreed that these discussions would be factored into the commissioning round and that Health Education England would be approached for financial support.

Without any commissioner support neonates is expected to be £0.424m adversely away from budget overall at the end of the year.

Hewitt Fertility Centre (HFC)
The HFC position continues to be impacted by two key issues

a) Underperformance in activity at Crown Street
b) Non-delivery of the Kings Joint Venture income (CIP scheme)

The financial impact to date is a net £0.443m behind plan with a projected £0.485m full year shortfall. This takes into account the implementation of the significant recovery plans that have been developed to date.

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.

Catherine Medical (CMC)
Catherine Medical income consists of private gynaecology and maternity. Whilst the cost base has been reduced in response to the lack of activity, this is not to the full extent of the income shortfall and at Month 5 CMC is £0.147m behind plan. There are plans in place to use CMC differently to generate additional income.

4. 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 CIP schemes is £1m for the full year. This is in relation to £0.5m in theatres which is being mitigated and £0.5m in relation to the Hewitt Fertility Centre which is also being mitigated and will be delivered in 2017/18.

5. Cash and borrowings

During 2015/16 the Trust was in receipt of £5.6m Interim Revenue Support from the Department of Health (DH). This 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 £5.6m Interim Revenue Support is due for repayment, in full, in March 2018. This will need to be replaced by longer term, planned support.

The Trust's financial plan for 2016/17 indicated a further requirement for cash of £7.7m. Whilst this request is being finalised centrally the Trust has in place a £2.5m working capital facility at an interest rate of 3.5%. NHS Improvement have been approached with regards to increasing this facility in the short term, and it has been confirmed that the working capital facility can be extended, in advance on a month by month basis, whilst DH assess the full national cash requirement. This is taken into account when the Trust produces its 13 week cash flow for submission to NHSI and the DH each month.

On 12 September 2016 the Trust was informed by NHSI that the monthly deadlines for utilisation requests had been brought forward in order to help DH identify where extensions to current facilities were required. The guidance also stated that organisations should not forecast the receipt of any STF funding in the 13 week cash flow. As a result of removing the STF from the cash flow (planned quarterly in arrears) the Trust has identified a need in its most recent submission to increase the working capital facility from £2.5m to £3m to meet immediate cash flow requirements.

The Trust has drawn down £1m from the working capital facility in September 2016. There is also a requirement to draw down a further £1m in October 2016. A further £1m will be required in November 2016 on the assumption that STF is not received.

NHSI's Distressed Financing team will make the application to increase the working capital facility based on the above requirements. The application will need Trust approval before it can be processed.

The cash balance as at the end of Month 5 was £4.3m.

6. Sustainability and Transformation Fund (STF)

The Trust met the criteria for the first payment and received £0.7m in relation to Quarter 1 in August 2016. The Trust expects to be on target to deliver the financial control total at Quarter 2.

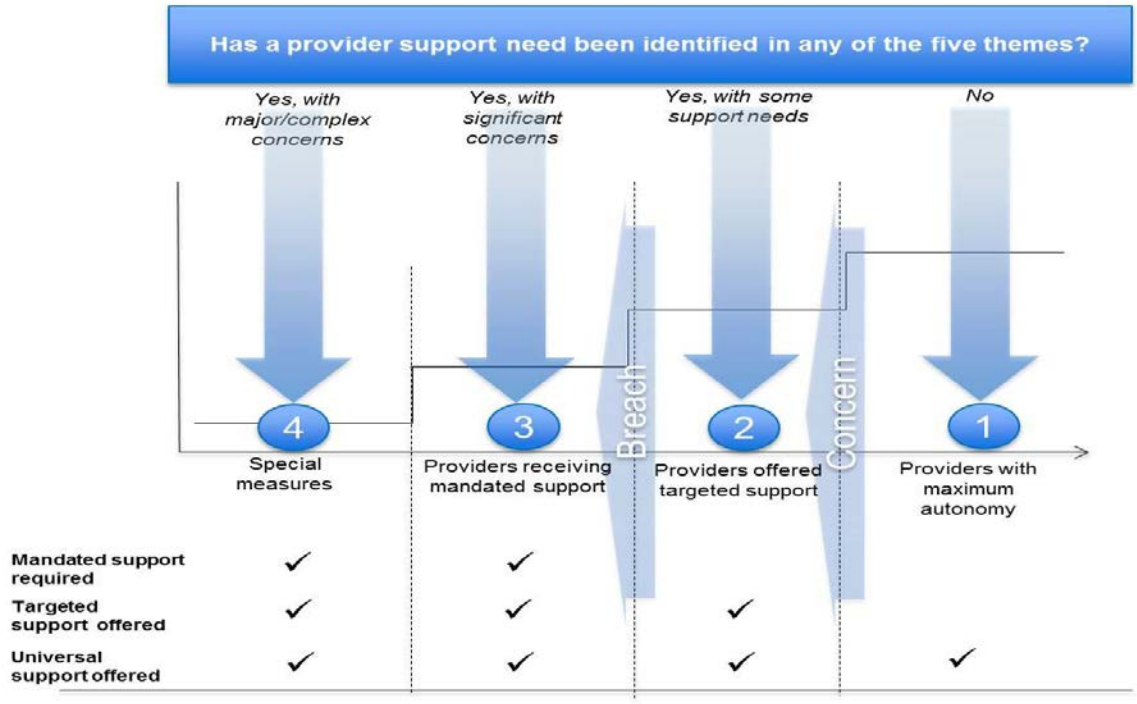
7. Single Oversight Framework

On 13th September NHSI published its new Single Oversight Framework (SOF) which takes effect from 1 October 2016. This was presented to FPBD committee for information in September 2016. It includes a new finance and use of resources framework as well as the segmenting of trusts into one of four groups on the basis of earned autonomy.

The new framework aims to help NHSI identify NHS providers' potential support needs across five key themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability

These themes underpin the segmentation of trusts as per the diagram below:



8. Conclusion & Recommendation

The Board are asked to note the Month 5 financial position

Appendices

Appendix 1: Board Finance Pack

Board Finance Pack
M5 Linked Pack.xlsx

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M5

YEAR ENDED 31 MARCH 2017

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
MONITOR SCORE: M5
YEAR ENDED 31 MARCH 2017

FINANCIAL SUSTAINABILITY RISK RATING	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR Budget	YEAR FOT
CAPITAL SERVICING CAPACITY (CSC)				
(a) EBITDA + Interest Receivable	(318)	(429)	(400)	(648)
(b) PDC + Interest Payable + Loans Repaid	875	808	2,712	2,547
CSC Ratio = (a) / (b)	**(0.36)**	**(0.53)**	**(0.15)**	**(0.25)**
MONITOR CSC SCORE	**1**	**1**	**1**	**1**
Ratio Score **4** = 2.5 **3** = 1.75 **2** = 1.25 **1** < 1.25				
LIQUIDITY				
(a) Cash for Liquidity Purposes	(3,488)	(5,128)	(8,924)	(8,924)
(b) Expenditure	45,035	44,908	108,297	107,870
(c) Daily Expenditure	300	299	301	300
Liquidity Ratio = (a) / (c)	**(11.6)**	**(17.1)**	**(29.7)**	**(29.8)**
MONITOR LIQUIDITY SCORE	**2**	**1**	**1**	**1**
Ratio Score **4** = 0 **3** = -7 **2** = -14 **1** < -14				
I&E MARGIN				
Deficit	3,068	3,098	7,000	7,000
Total Income	(44,713)	(44,471)	(107,887)	(107,210)
I&E Margin	**-6.86%**	**-6.97%**	**-6.49%**	**-6.53%**
MONITOR I&E MARGIN SCORE	**1**	**1**	**1**	**1**
Ratio Score **4** = 1% **3** = 0% **2** = -1% **1** < -1%				
I&E MARGIN VARIANCE				
I&E Margin	-6.86%	-6.97%	-6.49%	-6.53%
I&E Variance Margin	**0.83%**	**-0.11%**	**0.83%**	**-0.04%**
MONITOR I&E MARGIN VARIANCE SCORE	**4**	**3**	**4**	**4**
Ratio Score **4** = 0% **3** = -1% **2** = -2% **1** < -2%				
Overall Financial Sustainability Risk Rating	**2**	**2**	**2**	**2**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M5
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	(8,185)	(8,185)	(0)	(41,794)	(41,701)	(92)	(100,881)	(100,672)	(209)
Non-Clinical Income	(584)	(541)	(43)	(2,919)	(2,770)	(149)	(7,006)	(6,538)	(468)
Total Income	**(8,769)**	**(8,726)**	**(43)**	**(44,713)**	**(44,471)**	**(241)**	**(107,887)**	**(107,210)**	**(677)**
Expenditure									
Pay Costs	5,613	5,543	69	28,063	27,519	543	67,351	66,419	932
Non-Pay Costs	2,202	2,256	(54)	11,011	11,428	(417)	26,639	27,144	(505)
CNST	1,192	1,192	0	5,961	5,961	0	14,307	14,307	(0)
Total Expenditure	**9,006**	**8,992**	**15**	**45,035**	**44,908**	**126**	**108,297**	**107,870**	**427**
EBITDA	**237**	**266**	**(28)**	**322**	**437**	**(115)**	**410**	**660**	**(250)**
Technical Items									
Depreciation	375	375	0	1,875	1,862	13	4,500	4,417	84
Interest Payable	35	31	4	175	154	21	420	393	28
Interest Receivable	(1)	(1)	0	(4)	(8)	4	(10)	(11)	1
PDC Dividend	140	131	9	700	654	46	1,680	1,542	138
Profit / Loss on Disposal	0	0	0	0	0	0	0	0	0
Total Technical Items	**549**	**535**	**14**	**2,746**	**2,661**	**85**	**6,590**	**6,340**	**250**
(Surplus) / Deficit	**786**	**801**	**(15)**	**3,068**	**3,098**	**(30)**	**7,000**	**7,000**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
EXPENDITURE: M5
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	335	2	1,686	1,665	21	4,047	4,016	31
Medical	1,271	1,244	26	6,353	6,228	125	15,248	14,893	355
Nursing & Midwifery	2,504	2,470	34	12,520	12,106	413	30,047	29,534	514
Healthcare Assistants	391	390	1	1,955	1,975	(20)	4,691	4,691	0
Other Clinical	543	496	47	3,231	3,044	187	6,512	6,141	372
Admin Support	159	170	(11)	794	850	(56)	1,906	2,067	(161)
Corporate Services	358	368	(9)	1,274	1,304	(30)	4,299	4,384	(85)
Agency & Locum	50	70	(20)	250	346	(96)	600	694	(94)
Total Pay Costs	**5,613**	**5,543**	**69**	**28,063**	**27,519**	**543**	**67,351**	**66,419**	**932**
Non Pay Costs									
Clinical Suppplies	725	733	(8)	3,667	3,733	(66)	8,858	8,885	(26)
Non-Clinical Supplies	595	627	(32)	2,937	3,286	(349)	7,204	7,576	(373)
CNST	1,192	1,192	0	5,961	5,961	0	14,307	14,307	(0)
Premises & IT Costs	415	419	(4)	2,076	2,077	(1)	4,983	4,985	(2)
Service Contracts	466	476	(10)	2,331	2,332	(1)	5,594	5,697	(104)
Total Non-Pay Costs	**3,394**	**3,448**	**(54)**	**16,972**	**17,389**	**(417)**	**40,946**	**41,451**	**(505)**
Total Expenditure	**9,006**	**8,992**	**15**	**45,035**	**44,908**	**126**	**108,297**	**107,870**	**427**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M5
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	(3,328)	(3,419)	91	(16,719)	(17,180)	461	(40,771)	(41,400)	629
Expenditure	1,698	1,753	(55)	8,490	8,625	(135)	20,378	20,844	(467)
Total Maternity	**(1,630)**	**(1,666)**	**36**	**(8,229)**	**(8,555)**	**326**	**(20,393)**	**(20,556)**	**163**
Gynaecology									
Income	(1,902)	(1,979)	77	(10,036)	(10,419)	383	(23,965)	(24,784)	819
Expenditure	879	915	(36)	4,397	4,554	(157)	10,554	11,046	(492)
Total Gynaecology	**(1,023)**	**(1,065)**	**42**	**(5,639)**	**(5,865)**	**226**	**(13,411)**	**(13,738)**	**327**
Theatres									
Income	(42)	(42)	0	(210)	(209)	(1)	(504)	(500)	(4)
Expenditure	608	649	(41)	3,041	3,230	(190)	7,298	7,687	(389)
Total Theatres	**566**	**606**	**(40)**	**2,831**	**3,022**	**(191)**	**6,794**	**7,186**	**(392)**
Neonatal									
Income	(1,409)	(1,387)	(22)	(7,044)	(6,814)	(229)	(16,908)	(16,444)	(464)
Expenditure	997	987	10	4,986	4,822	164	11,967	11,926	40
Total Neonatal	**(411)**	**(400)**	**(12)**	**(2,058)**	**(1,992)**	**(66)**	**(4,941)**	**(4,518)**	**(424)**
Hewitt Centre									
Income	(935)	(907)	(28)	(4,924)	(4,300)	(624)	(11,474)	(10,514)	(960)
Expenditure	721	698	23	3,645	3,465	180	8,805	8,330	475
Total Hewitt Centre	**(214)**	**(209)**	**(5)**	**(1,279)**	**(835)**	**(443)**	**(2,669)**	**(2,184)**	**(485)**
Genetics									
Income	(596)	(567)	(29)	(2,977)	(2,799)	(178)	(7,143)	(6,683)	(460)
Expenditure	446	456	(10)	2,232	2,123	109	5,358	5,086	272
Total Genetics	**(149)**	**(110)**	**(39)**	**(745)**	**(676)**	**(69)**	**(1,785)**	**(1,597)**	**(188)**
Catharine Medical Centre									
Income	(101)	(14)	(88)	(341)	(108)	(233)	(817)	(367)	(450)
Expenditure	80	17	63	233	147	86	557	264	293
Total Catharine Medical Centre	**(22)**	**3**	**(25)**	**(109)**	**39**	**(147)**	**(260)**	**(103)**	**(157)**
Clinical Support & CNST									
Income	(22)	(21)	(1)	(122)	(137)	15	(291)	(298)	7
Expenditure	733	712	21	3,664	3,614	49	8,793	8,718	75
Total Clinical Support & CNST	**710**	**691**	**19**	**3,541**	**3,477**	**64**	**8,502**	**8,420**	**82**
Corporate									
Income	(435)	(391)	(44)	(2,339)	(2,505)	166	(6,015)	(6,220)	205
Expenditure	3,393	3,340	53	17,093	16,989	105	41,178	40,309	869
Total Corporate	**2,958**	**2,950**	**9**	**14,755**	**14,484**	**271**	**35,163**	**34,089**	**1,074**
(Surplus) / Deficit	**786**	**801**	**(15)**	**3,068**	**3,098**	**(30)**	**7,000**	**7,000**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BALANCE SHEET: M5
YEAR ENDED 31 MARCH 2017

BALANCE SHEET £'000	YEAR TO DATE Opening	M05 Actual	Movement
Non Current Assets	**70,529**	**69,557**	(972)
Current Assets			
Cash	3,225	4,317	1,092
Debtors	4,302	7,077	2,775
Inventories	326	307	(19)
Total Current Assets	**7,853**	**11,701**	**3,848**
Liabilities			
Creditors due < 1 year	(8,056)	(14,153)	(6,097)
Creditors due > 1 year	(1,748)	(1,766)	(18)
Commercial loan	(10,794)	(10,795)	(1)
Provisions	(2,392)	(2,250)	142
Total Liabilities	**(22,990)**	**(28,964)**	(5,974)
TOTAL ASSETS EMPLOYED	**55,392**	**52,294**	**(3,098)**
Taxpayers Equity			
PDC	36,610	36,610	0
Revaluation Reserve	10,019	10,019	0
Retained Earnings	8,763	5,665	(3,098)
TOTAL TAXPAYERS EQUITY	**55,392**	**52,294**	**(3,098)**

Agenda item no:	16/254

Meeting:	Board of Directors

Date:	7 October 2016

Title:	Corporate Risk Register Overview

Report to be considered in public or private?	Public

Purpose - what question does this report seek to answer?	1. What changes have been made to corporate risks since the last Committee meeting? 2. What response is required by the Committee?							
Report For:	**I**nformation	(✓)	**D**ecision	(✓)	**E**scalation	(✓)	**A**ssurance	(✓)

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

Reference/s:	N/A

Resource impact:	

What action is required at this meeting?	To receive the report and note changes

Presented by:	Dianne Brown, Director of Nursing & Midwifery

Prepared by:	Risk 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	

Which standard/s does this issue relate to:	
Care Quality Commission Hospital Inspection Regime Indicator	ALL
Board Assurance Framework Risk	ALL

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 Corporate Risk Committee review changes to service level risks and maintain the Corporate Risk Register. It is for the Corporate Risk Committee to form a view of their satisfaction with the assurance(s) provided and identify any gaps and actions they consider necessary. However, the Board are required to periodically review changes made to the Corporate Risk Register so that they can then ensure that the risks being managed at on the BAF are adequately supported by sub-risks.

This report provides an update on changes made to the Corporate Risk Register since the last update to the Board of Directors.

2. Key Themes

a) New Risks

Since the last update there have been three additional risks escalated to the Corporate Risk Register.

Risk ID	Description of Risk	Initial Score	Current Score	Risk Owner (& Exec)	Reason for Escalation to Corporate Risk Register
2018	Risk: Inability to provide a good, safe and effective Gynaecology Emergency Service for patients. Cause: Insufficient clinical and managerial overview and resource in Gynaecology Emergency Services to meet the increasing demands. 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. Impact: Poor patient experience, potential untoward incidents, complaints and litigation, failure to meet regulatory requirements and reputation damage.	10	10	Ruth Stubbs (Andrew Loughney)	Nursing workforce review submitted and papers submitted to GACA. Requires business case development and oversight as a Corporate Risk.
2044	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 requirement.	10	10	Simon Davidson (Vanessa Harris)	New risk highlighted by Estates
2039	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	16	16	Abraham Ssenoga (Andrew Loughney)	Escalated by Safety Senate in August 2016 following discussions regarding upcoming evaluation by the Critical Care Network

	providing this care.				

b) Closed Risks

Since the last update no risks have been removed from the Corporate Risk Register:

c) Changes to the Existing Risks

Since the last update there have been two risks that have had their risk ratings changed.

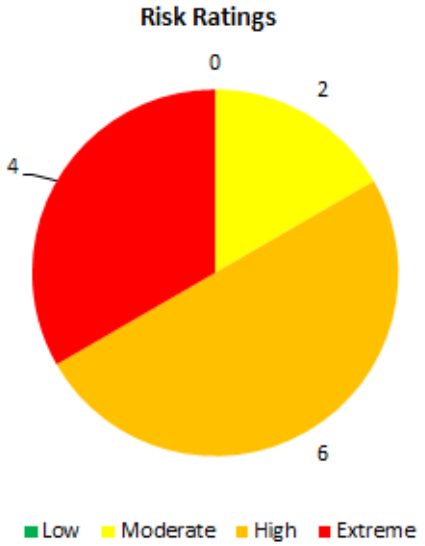
Risk ID	Description of Risk	Initial Score	Current Score	Risk Owner (& Exec)	Reason for Changes
1709	Risk : Insufficient consultant or senior medical cover. Caused by high levels of sickness/absence/maternity leave; insufficient investment in or supply of senior medical staff; high vacancy factor; insufficient workforce planning or adjustment for case-mix; or insufficient supply of suitably qualified/experienced staff. 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	6	12	Michelle Turner	Likelihood increased to a four following discussions at the Corporate Risk Committee in July
1983	Medicines Management : 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.	16	12	Paul Skipper (Jeff Johnston)	Likelihood reduced to a 3 due to an ongoing review with IT to put in place a named individual to oversee

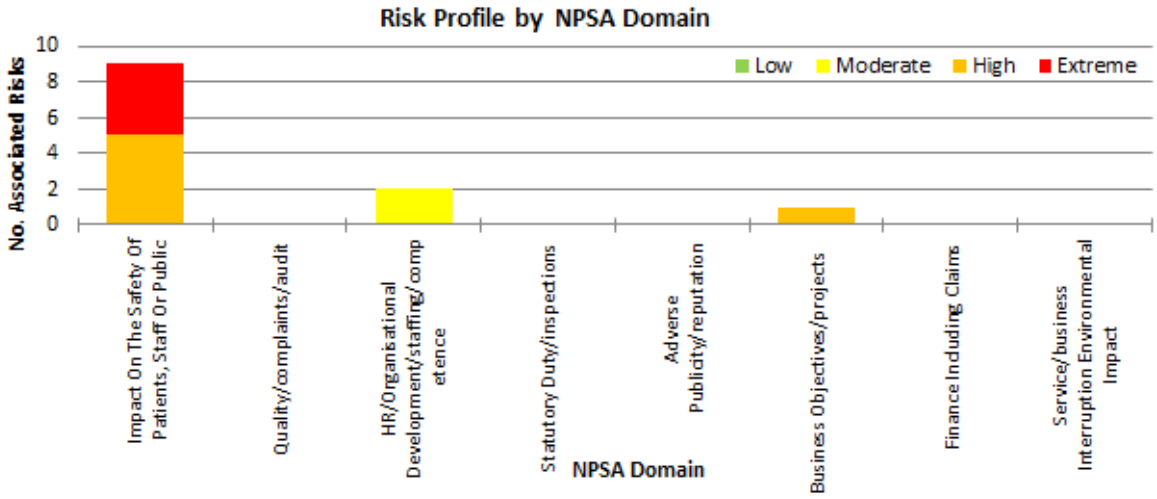
3. Recommendations

That the Board:

1. review the changes approved since they last received the Corporate Risk Register
2. continue to support the Corporate Risk Committee in the management of the Register.

3. Appendix – Full Corporate Risk Register Dashboard





1-3	Very low risk
4-6	Moderate
8-12	High
15+	Extreme

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. Rotas from lead Employer due to be issued in June with numbers for August rotation - review of risk based on this information is due.

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 due to the ongoing further action re: the contract. Previous risk owner has now left the organisation. POCT provision is currently out to tender
HR	1709	HR/Organisational Development/	Insufficient consultant or senior medical cover. 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. 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. Review of WFP for medical staff (juniors & consultant) being undertaken in conjunction with General Manager for Women's & Children's Service - 1/4ly updates 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 February 2016 IG Committee.

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. 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 (Michelle Turner)	Currently clinical genetics is breaching 18 weeks for patients who need an appointment with some pushing 40 weeeks. 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. 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.
Safeguarding	1895	Impact On The Safety Of Patient	Risk: Lack of robust systems and processes to ensure the safeguarding of LWH patients. Cause: Change in management, legislative requirements, lack of policy, training and governance. Effect: Poor staff morale, inadequate organisational leadership, assurance and engagement. 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. 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 Caused by high levels of sickness/absence/maternity leave; insufficient investment in staffing; high vacancy factor; insufficient workforce planning; or insufficient supply qualified staff 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. Risk review was due in June
Finance	1962	Business Objectives/projects	Failure to implement Future Generations strategy. 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. 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. 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)	Revised Future Generations project risk. Rearticulated after publication of the Trust's Future Generation Strategy to relect new focus on CCG implementation in conjunction with Healthy Liverpool programme.

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. 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. Effect: Potential for missed diagnosis, lack of appropriate intervention, treatment and care resulting in severe harm or death of patient(s). 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. Resolution of the root cause requires negotiation of an explicit Service Level Agreement with RLUH and documentation of robust policy and procedures in relation to the external provision of the radiology reporting service. Risk review was due in June
Women's & Childre n'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 Possibl e	12	12	GACA	Ruth Stubbs (Andrew Loughney)	Implementation of NatSSIPS / LocSSIPs and meeting of the Standards for Safer Invasive Procedures will have resource implications as the standards explicitly require procedure times to include sufficient time for checklist completion and adequate staffing and time to enable described processes to be completed. This will impact on all services conducting invasive procedures.

Emergency Department	1974	Impact On The Safety Of Patient	Inadequate medical staffing in GED to deliver Emergency care and review of planned re attendance at emergency care clinics. This is as a result of the requirement for Junior Doctors to cross cover at times in their shift covering ward patient needs, maternity care at night, theatre assistance and emergency calls. There are times when the unit is left staffed by a junior doctor for long periods of time. Impacting patient care , delays in diagnosis . A known incident of a double rostering error - allocation of Registrar to both maternity and GED., Same date and time.	19/04/2016	3 Moderate	5 Almost Certain	15	15	PPF	Shaun Curran (Andrew Loughney)	Escalated to Corporate Risk as issue requires recruitment solution beyond the control of the service. This risk links to corporate risks 1709/143 and 1953.
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. Risk score lowered at most recent review.

Agenda item no:	16/255

Meeting:	Board of Directors

Date:	7 October 2016

Title:	Board Assurance Framework

Report to be considered in public or private?	Public

Purpose - what question does this report seek to answer?	Does the Board Assurance Framework provide assurance that the key risks to strategic aims are being controlled/ mitigated?							
Report For:	**I**nformation	(✓)	**D**ecision	(✓)	**E**scalation	(✓)	**A**ssurance	(✓)

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

Reference/s:	N/A

Resource impact:	

What action is required at this meeting?	Review of the BAF and consideration of any change proposals.

Presented by:	Colin Reid, Trust Secretary

Prepared by:	Risk 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	

Which standard/s does this issue relate to:	
Care Quality Commission Hospital Inspection Regime Indicator	All
Board Assurance Framework Risk	All

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	
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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: 16 September 2016
The GACA Committee agreed to de-escalate Risk 1735 (1e on the BAF). They noted that there is a robust system in place for managing alerts, overseen by the Safety Senate. It was therefore agreed that this risk be de-escalated and managed locally on the Governance Risk register.

The Committee was informed by the Associate Director of Operations that the Neonatal Transport Service does not have enough Junior Doctors to cover the rota. The Committee therefore agreed to a new risk being added to the BAF after discussion at the Neonatal MDT. This is new Risk 1o on the BAF.

Putting People First Committee: 23 September 2016
The PPF Committee made no changes to the BAF risks for which they are accountable. They did however express their view that Risk 1732 (3a on the BAF) which PPF and GACA have shared oversight of should instead be the sole responsibility of GACA.

Finance, Performance & Business Development Committee: 26 September 2016

The Committee agreed that Risk 1663 (5a on the BAF) should be replaced by two component parts. One (5f on the BAF) would describe the risk of regulatory intervention and impact as a result the 2016/17 financial position. The other (5g on the BAF) would describe the risk in relation to the achievement of the 2016/17 financial position. This is set out below:-

	Risk	Cause	Effect	Suggested rating
I	The Trust does not have a financially sustainable plan in 2016/17	Tariff insufficiency Commissioner Intentions CNST premiums Inability to identify CIP	Requirement for Distressed Financing Breach of Licence Conditions	5x5 = 25
II	The Trust does not deliver the 2016/17 financial plan and control total	Lack of operational grip and financial controls	Further regulatory intervention/ special measures	3X5 = 15

FPBD also approved the risk appetite levels for 2016-17 for the risks for which they are accountable.

Other Issues

RSM were asked to carry out an audit of the Board Assurance Framework and Risk Management escalation processes. The audit was carried out between 18 and 22 July.

RSM reported back through the Corporate Risk Committee in September with the findings of their audit. They confirmed that the departmental restructure within the Governance Team has led to improvements in risk management. They also reported finding that the restructure has led to changes to the central reporting of risk at a corporate level that have strengthened strategic overview.

As a result RSM were able to provide reasonable assurance that the controls upon which the organisation relies to manage risk are suitably designed and are being consistently applied. This is a vast improvement from the situation in 2014 when the Trust received a warning notice as a result of deficiencies in this area. It also represents a marked improvement from 2015 when reasonable assurance could not be provided by internal audit.

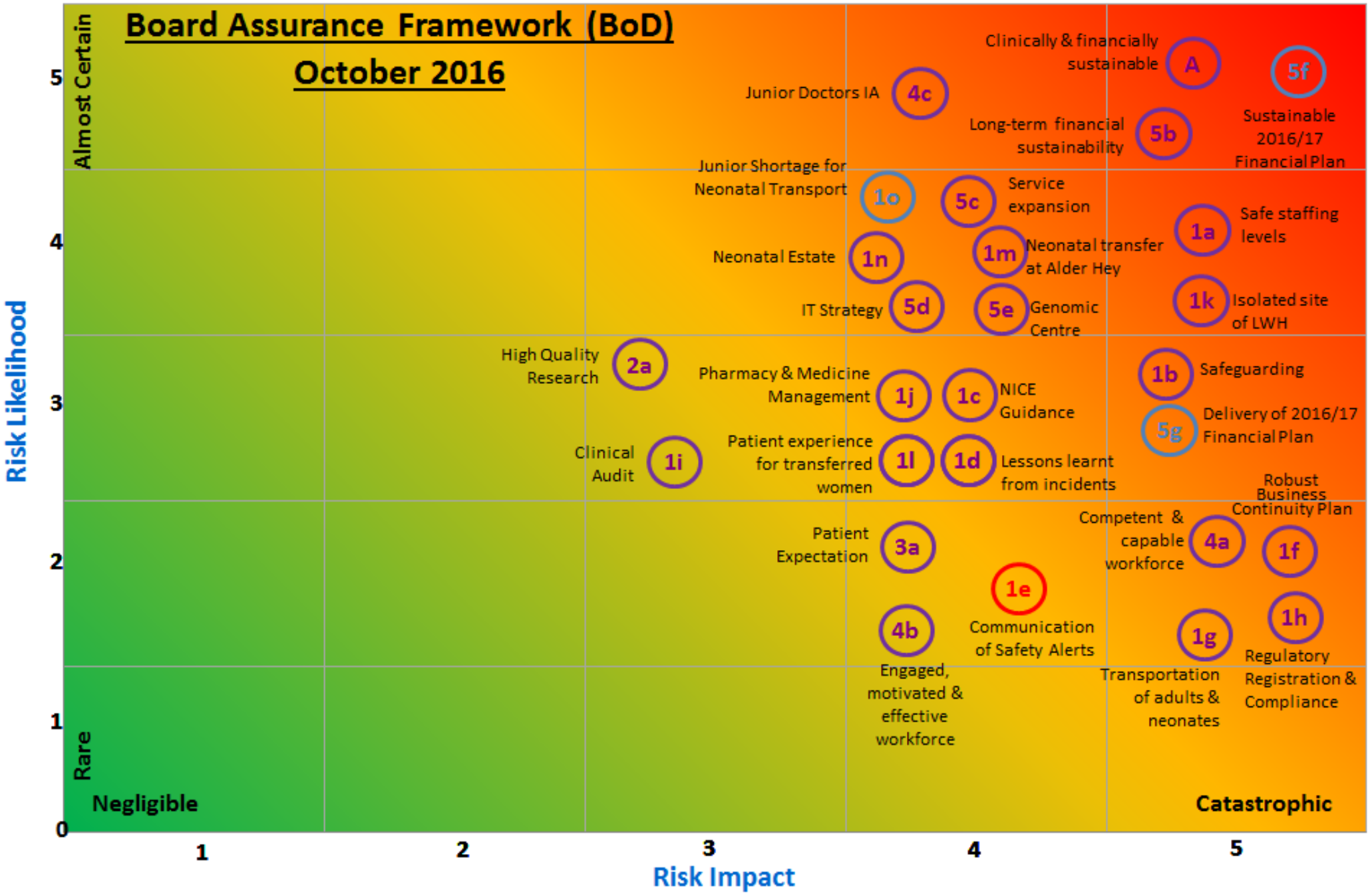
Corporate Risk Committee accepted the findings of the audit and will now monitor progress against the agreed actions.

3. Conclusions and Recommendations

It is recommended that the Board:-

a) Review the BAF risks, their presented risk grading, controls, assurances and related gaps and required actions.
b) Note and communicate any change proposals.

Appendix 1 – Heat-map of BAF Risks



Appendix 2 – Full details of BAF Risks

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

1	**1. To deliver SAFE services** **Risk Appetite - Low**				**Initial**	**Current**					
1	**a)** To ensure appropriate and safe staffing levels are maintained **Risk:** Failure to have operational grip / effective utilisation of resource . **Cause:** 1) insufficient investment in clinical staffing to meet recommended staffing levels associated with Maternity Tariff 2) high sickness absence levels in midwifery workforce **Effect:** Risk to financial viability associated with additional investment in nurse/midwifery staffing. Inadequate numbers of staff available to deliver services **Impact:** Potential risk to patient safety and experience; risk to continuity of service rating; potential breach of CQC licence conditions **Ulysses Ref: 1731.**	146 1709 1863 1953	Putting People First Strategy	DONM (GACA)	**5x4 =20**	**5x4= 20**	•Staffing Policies •Escalation Policies •Daily Monitoring Activity and Acuity •Incident Reporting Policy and Process •Bank •Sickness and Absence Policy •Health and Well Being Policy •Unify returns •Monitoring Performance Data • Fill rates	•Annual Staffing Review • Staff Survey & Pulse Survey •KPI's •Patient Survey •Claims Litigation Incident PALS Report • Monthly performance data (sickness) •Nursing and Midwifery Board Minutes 08-04-14, (PPF Committee, 20-06-14, item 14/15/27) • Leadership Programme Proposal (PPF Committee, 20-06-14, item 14/15/16) • Evidence on NHS Choices • 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. • Staff feed back from Staff survey & Pulse Survey to be considered at PPF,	December, 2016
1	**b)** To comply with national standards for the safeguarding of children and adults **Risk:** Failure to ensure effective arrangements with partners to safeguard vulnerable adults and children **Cause:** Lack of direction and control , systems and processes **Effect:** Potential failure to prevent harm; damage to Trust reputation **Impact:** May result in avoidable harm; may result in regulatory action; financial penalty; prosecution . **Ulysses Ref: 1732**	1895	Quality Strategy Safeguarding Strategy (draft)	DONM (GACA)	**5x3 =15**	**5x3= 15**	•Safeguarding Strategy •Policy •Mandatory Training • KPI's • Partnership/Networking arrangements • Safeguarding Board • Further interim support identified	•Peer review & associated action plan • Audit (associated with Regulation 11) • Contractual KPI's • Annual Safeguarding Report. • 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

1	**c)** 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). **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
1	**d)** To ensure lessons are learnt shared, and appropriate change enacted from the reporting and investigation of incidents locally and across the wider NHS Community. **Risk:** Risk of repeat and costly events, regulatory action, service interruption, poor staff and patient experience **Cause**: Poor system and training for reporting, recording, and investigating incidents **Effect:** Compromised safety and learning outcomes **Impact:** Regulatory action, increased cost, poor quality outcomes. **Ulysses Ref: 1734**	154 902 1707 1597	Quality Strategy Risk Management Strategy	DONM (GACA)	**4X4 =16**	**4X3= 12**	•Clear Policies(incident and SUI) • 10 yr. look back •Mandatory Training •RCA training •Data Base recording and reporting	NRLS •Performance Reports to GACA • Complaints, Litigation, Incidents & PALS (CLIP) Report. (GACA 28-08-2014, Item,14/15/68) •Serious Untoward Incident Report. (GACA 28-08-2014, Item,14/15/69) • RCA training delivered September 2015 • NW Quality and Safety Forum member • Quarterly SEE report	Yes	• Gap analysis of current themes. • Evidence/ Assurance that there are no un-escalated incidents. •Formal process for review/assurance to be undertaken by clinical audit	December, 2016
1	**f)** 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. **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		

1	**g)** Transportation of adults and neonates across the critical care network **Risk:** Patient safety compromised by inadequate arrangements, pathways, protocols, systems and equipment required for the safe transportation of 'critical care' patients **Cause:** Patients in 'critical care' require treatment outside the scope and expertise available at LWH Effect: Vulnerable patients potentially exposed to journey hazards **Impact:** Patient safety and experience could be compromised. **Ulysses Ref: 1737.**		Risk Management Strategy Putting People First Strategy	ADOps (GACA)	**5x4 =20**	**5x2= 10**	Transportation critical care neonates: • Specialised cots for transport • Dedicated specialised trained staff •Policy and procedure for transportation •Cot Bureau - patient allocated specific cot Transportation of Adults - critical care: •Critical care network standards •Dedicated trained staff •Transport Policy •Education training/support from networks •Escalation Policy •External KPI's	•Compliance with CRG specification NNTS •External KPI's- reported to NNW and CMNN		• Seek patient's and clinician's feedback on the handling of transfers	January, 2017
1	**h)** Maintaining appropriate Regulatory Registration and Compliance **Risk:** Insufficient robust processes and management systems that provide regulatory compliance performance and assurance. **Cause**: Failure to provide evidence and assurance to regulatory agencies **Effect:** Enforcement action, prosecution, financial penalties, image and reputational damage **Impact:** loss of commissioners/patient confidence in provision of services. **Ulysses Ref: 1739.**		Business Continuity Plan Risk Management Strategy Putting People First Strategy Quality Strategy	DONM (GACA)	**5x4 =20**	**5x2= 10**	• Monitor meetings • CQC engagement meetings • 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 • 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
1	**i)** To develop and support a comprehensive Clinical Audit provision **Risk:** Failure to meet Statutory and Mandatory requirements, CPD for Clinicians **Cause:** Lack of robust planning and monitoring, training and support **Effect:** Breach of Statutory targets, failure of Trust to learn from clinical audit results **Impact**: Potential action by CQC, image and reputation damage. **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

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

1	l) Patient Experience for Transferred Women **Risk:** Women are transferred out of Liverpool Women's for delivery elsewhere **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. **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. **Impact:** Poor patient experience for transferred women, continued growth of the maternity service will not be possible without an expansion of neonatal capacity. **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
1	**m)** Neonatal Transfer Team **Risk:** Patient safety risk arising from lack of capacity to transfer babies whilst the neonatal team are operating their service at Alder Hey **Cause:** Lack of cot capacity to accept urgent transfers of babies requiring surgical care at Alder Hey Hospital requires transport team to remain with babies on this site to provide direct care during treatment and until the baby is stabilised Lack of second transport team to support retrieval/transfer of babies from other units whilst **their** service is in operation **Effect:** Inability to maintain service delivery, no official transfer of care of babies to clinicians at Alder Hey **Impact:** Moderate to severe harm to patients. **Ulysses Ref: 1944**		Risk Management Strategy	ADOps (GACA)	**4x4 =16**	**4x4= 16**	• Escalation to Alder Hey & LWH Exec Teams any delays to discharge • Creation of breach form for any delays • Meetings with Neonatal network and Alder Hey to resolve capacity issues	• Breach analysis forms • Incident reports of delayed discharges • Escalations to Exec on call	Yes	Resolution for capacity issues	January, 2017

1	**n)** 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. **Cause:** Increased intensity, rising demand and over occupancy of Neonatal Unit **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. **Impact**: Moderate to severe harm to patients. **Ulysses Ref: 1944**		Risk Management Strategy	ADOps (FPBD)	**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
1	**o)** Junior Doctors Shortage on Neonatal Transport **Risk:** Inability to provide a Neonatal Transport service **Cause:** Shortage of junior doctors, skills gaps within junior doctor workforce **Effect:** Gaps in the Neonatal Transport Team rota, inability to provide a neonatal transport service **Impact**: Failure to transfer seriously ill patients, moderate to severe harm to patients. **Ulysses Ref: Awaiting**		Risk Management Strategy	ADOps (GACA)	**4x4 =16**	**4x4= 16**	• Training for ANNPs • Assessments of junior doctors against competency framework • Upskilling of existing ST4s • Collaboration on business plan to NHS England for North-West wide solution • Working with Manchester and NHS England on interim plan	• Letters of escalation to NHS England • Correspondence with Manchester • Training records for ANNPs and ST4s • Meetings with NHS England	Yes	Business case submission and decision from NHS England	March, 2017

	2. To participate in high quality research and to deliver the most effective outcomes **Risk Appetite - Low**				**Initial**	**Current**						
2	**a)** Research adds value, and enhances services and reputation of the Trust **Risk:** Research is not linked to strategic aims **Cause:** Research work plan potentially insular and not connected to quality improvement of service provision **Effect:** Research fails to contribute to the work of LWH **Impact**: The cost of research function fails to yield measurable effective outcomes. **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 • BT R+D Internal Audit Report	None		

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

4	**To develop a well led, capable, motivated and entrepreneurial workforce** **Risk Appetite - Moderate**										
	a) 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 **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 **Cause**: Lack of time, inefficient processes or insufficient prioritisation by managers. **Effect**: Employees not competent or equipped to ensure patient safety and maintenance of the organisational reputation **Impact**: May result in unsafe care to patients, insufficient improvements in quality and breach of CQC conditions of registration resulting in regulatory action. **Ulysses Ref: 1743.**	1707170 4169014 45	Putting People First Strategy	DWM (PPF)	**5x2 =10**	**5x2= 10**	•Clear Policies•Metrics(KPI's)• Performance Monitoring•Training Regime•Local OLM reports• Induction •All Staff aware of role and accountabilities	•Monthly Performance Report (Ops Board/Board of Directors)• Internal audit report (PPF and Audit Committee)• Annual Staff Survey (PPF Committee 20-06-14, item 14/15/10)• Health and Well Being Strategy (PPF Committee 20-06-14, item 14/15/11)•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	Nov 2014April 2015

	b) 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**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.**Cause**: Lack of time, inefficient processes or insufficient priority assigned by management.**Effect:** Trust fails to become the provider and employer of choice for patient, commissioners, and employees **Impact:** impact on Trust's ability to recruit and retain the best, and on the Trust's ability to achieve its strategic vision.**Ulysses Ref: 1744.**		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• Consultant appraisal linked to Revalidation process• Managers clear about their responsibility to undertake annual appraisals with their team• Pay progression linked to appraisal and mandatory training compliance.• Appraisal guides available for Managers and employees• Monthly reporting at Departmental/ Divisional and organisation wide level via Performance Report.• Targeted intervention for areas identified as under-=performing• Training programme available for managers• All new starters complete mandatory training Inc. PDR training as part of corporate induction ensuring awareness of their responsibilities. • Consultant revalidation requires mandatory training compliance• Extensive mandatory training programme available via classes, online resources and study days• Monitored at Education Governance Committee.	• CQC visit of April 2014 identified improvement in appraisal rates and recorded compliance with 'Supporting workers' - outcome 14.• Pay progression policy recently implemented. Impact of policy will not be evaluated until 2015-16• Increase in managers attending training programme• Annual internal audit of policy by Trust's audit partners. Due to report Q3 2014-15,• Review by Trust's audit partners showed that system and processes used are effective if applied consistently across the Trust.•Compliance with GMC Revalidation requirements• Monthly performance report for June 2014 identifies organisational compliance at 84% for mandatory training. Areas identified requiring intervention Imaging & Maternity.	Yes	Review contract and JD templates to ensure they accurately articulate managers' responsibilities with respect to appraisal and mandatory training compliance for their team members.Complete OLM project in accordance with agreed timescalesExpedite roll out and promotion of e-learningEvaluate impact of pay progression policy.Develop project plan to implement Self Service	Nov 2014Dec 2014Dec 2014Mar 2015
	c) To maintain delivery of clinical services 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. **Cause:** Industrial action by Junior Doctors **Effect:** Trust is unable to deliver clinical services. **Impact:** Damage to reputation, income and access targets. **Ulysses Ref: 1909.**		Putting People First Strategy	DWM (PPF)	**4x3 =12**	**4x5= 20**	• Pro-formas sent to CD's to assess impact of industrial action on clinical activity and to make contingency arrangements. • Pro-forma sent to junior and Trust grade doctors re "intentions". • Lessons learnt from industrial action taken previously • All planned industrial action is now completed (awaiting results of national ballot on 7 July	All CD's and Heads od Service have plans in place (SMT 6/1/16) Pro-forma re service provisison sent to all CD's 5/1/16 for completion. 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 Review risk upon result of ballot	April 2016 July 2016

5	**To be ambitious and efficient and make the best use of available resources** **Risk Appetite - Significant**										
b	To deliver long term financial sustainability **Risk:** The Trust is not financially sustainable beyond 2016/17 **Cause:** Tariff insufficiency, commissioner intentions, CNST premiums and liabilities, non delivery of CIP **Effect:** Lack of financial stability and ability to fund services, insolvency and Trust unable to deliver services **Impact:** Invocation of Monitor sanctions-special measures. **Ulysses Ref: 1986.**		Risk management Strategy	DOF (FPBD)	**5x5 =25**	**5x5= 25**	• 5 year financial model produced giving early indication of issues • Advisors with relevant experience (PWC) engaged early to review strategic options • Early and continuing dialogue with Monitor • Active engagement with CCG's through the Healthy Liverpool Programme • Final Business Case to Trust Board in Dec 15 • Clinical engagement through regular reporting to Trust Management Group	• 5yr plan presented to Board, June, 2014 • 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
c	To take forward plans to develop services nationally and internationally **Risk:** Non-delivery of the expected return from expansion investment **Cause:** Demand less than expected **Effect:** Loss of potential revenue **Impact:** Costs could exceed income of the project adding additional pressure to the financial position of the Trust. **Ulysses Ref: 1748.**		Risk Management Strategy	DOF (FPBD)	**4x4 =16**	**4x4= 16**	• Detailed project plan in place • Experienced manager appointed to lead expansion • Key clinical staff identified to implement plan •Legal agreements completed • Experienced advisors engaged (e.g. Pinsent Mason) •Capital planned for all projects and ITFF funding in place	• Business Case for expansion approved by Trust Board in December 2013 • Legal contracts reviewed by FPBD • Quarterly update to FPBD from October 2014 onwards	None	Continuing review of performance	Mar-17
d	Fail to achieve benefits from the IT Strategy**Risk:** Failure to successfully deliver the IM&T Strategy**Cause:** Poor programme management controls**Effect:** Programme running over budget, out of scope, late or non delivery of stated benefits realisation**Impact:** Trust being non compliant with national initiatives, data collection requirements or financial compliance. **Ulysses Ref: 1750.**	**902**	IM&T Strategy	DOF (FPBD)	**4x4 =16**	**4x4= 16**	• IM&T Business case• Capital Reporting Plan in place• Project Management Office in place• Project Plan established• Programme Board in place and meeting regularly• Regular reports to FPBD• Robust business continuity plan in place• Supplier contracts• Replicated data centres• Disaster recovery plans• System Training• Doing IT Right Strategy• IM&T policies• Data Protection Policy• Data Quality Policy• Structured change control in line with ITIL	• IM&T business case approved (TB) • Programme Board in place, minutes available• Quarterly FPBD reports	Yes	New Plan for EDMS and Bed Management to be formulated July 2016. EPR business case to be implemented per project plan	Jul-16

e	To develop a sustainable Genomic Centre **Risk:** Potential loss of service following re-commissioning of genetics nationally - unsuccessful tender service cost **Cause**: Relatively small unit **Effect**: Loss of service and financial contribution of £1.5m per-p.a. **Impact**: Loss of genetics service through failure to engage appropriately in the future model of genetics service provision in Liverpool / North West . **Ulysses Ref: 1749.**		Risk Management Strategy	DOF (FPBD)	**4x4 =16**	**4x4= 16**	• External Engagement through the Liverpool Health Partners • Genetics strategy group in place • Significant engagement with NHS England through national lead • Successful 100,000 genome bid • Developed MOU to collaborate with LCL to meet service specification	• Successful submission of tender to NHS England 100,000 genome project • MOU with LCL	Yes	• Tender date for genomic hub yet to be confirmed. To be kept under review	TBC by NHS Genomics
f	To deliver the financial plan beyond 2016/17 **Risk:** The Trust does not have a financially sustainable plan in 2016/17 **Cause:** Tariff insufficiency, commissioner intentions, CNST premiums and liabilities and inability to identify further significant CIPs **Effect:** Requirement for Distressed Financing, Breach of Licence Conditions **Impact:** Regulatory Intervention **Ulysses Ref: TBC**	1381	Risk Management Strategy	DOF (FPBD)	**5x5 =25**	**5x5= 25**	• Zero based budget methodology adopted • Voluntary turnaround process adopted to identify robust CIP schemes • FPBD & Board approval of budgets • Sign off of budgets by accountable officers • Monthly reporting to all budget holders with variance analysis • Monthly reporting to FPBD & Trust Board • Monthly reporting to Monitor	• 2016/17 plan approved by Trust Board in April • Performance & Finance Report presented monthly to FPBD • Finance & CIP achievement reported monthly to FPBD, Executive Team and Operational Board • Monthly budget holder meetings • Monthly reports to monitor • Internal audit review of budgetary controls	None	Ongoing review of position	Mar-17
g	To deliver the financial plan beyond 2016/17 **Risk:** The Trust does not deliver the 2016/17 financial plan and control total **Cause:** Lack of operational grip and financial controls **Effect: N**on-delivery of the financial plan and reduction in available cash **Impact:** Further regulatory intervention and special measures **Ulysses Ref: TBC**	1381	Risk Management Strategy	DOF (FPBD)	**5x3 =15**	**5x3= 15**	• Zero based budget methodology adopted • Voluntary turnaround process adopted to identify robust CIP schemes • FPBD & Board approval of budgets • Sign off of budgets by accountable officers • Monthly reporting to all budget holders with variance analysis • Monthly reporting to FPBD & Trust Board • Monthly reporting to Monitor	• 2016/17 plan approved by Trust Board in April • Performance & Finance Report presented monthly to FPBD • Finance & CIP achievement reported monthly to FPBD, Executive Team and Operational Board • Monthly budget holder meetings • Monthly reports to monitor • Internal audit review of budgetary controls	None	Ongoing review of position	Mar-17

16/256
Review of risk impacts of items discussed

16/257
Any other business

16/258
Review of meeting