Meeting of the Board of Directors
HELD IN PUBLIC
Friday 2 September 2016 at Liverpool Women's Hospital at 1000-1245
Board Room

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard	BAF Risk
	Thank you to Staff - Neonatal				1000 10mins		
204	Apologies for absence & Declarations of interest	Receive apologies	Verbal	Chair		-	-
205	Patient Story	To receive a patient story	verbal	Patient/ Chief Executive	1010 20mins		
206	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		Well Led	-
207	Minutes of the previous meetings held on Friday 1 July 2016	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1030 10mins	Well Led	-
208	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written/verbal	Chair		Well Led	-
209	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1040 10mins	-	-
210	Chief Executive Report	Report key developments and announce items of significance not elsewhere	Verbal	Chief Executive	1050 10mins	Well Led	-

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard	BAF Risk
211	100,000 genomes Project	To provide assurance surrounding the status and delivery of the project.	Presentation	Angela Douglas, Scientific Director, Genetics Department	1100 20mins		
212	Emergency Preparedness - self-assessment of compliance with the core standards	To agree the findings of the self-assessment and action plan	Paper	Associate Director of Operations	1120 10mins		
BOARD ASSURANCE							
213	Chair's Report from the Finance Performance and Business Development Committee held on 20 June 2016	Receive assurance and any escalated risks	Written	Committee Chair	1130 20mins	Well Led	5a,b,c,d,e
214	Chair's Report from the Governance and Clinical Assurance Committee held on	Receive assurance and any escalated risks	Written	Committee Chair		Well Led	
215	Chair's Report from the Audit Committee held on	Receive assurance	Written	Committee Chair		Well Led	
TRUST PERFORMANCE							
216	Safety, Experience and Effectiveness Quarter 1 Report	Review the latest Trust SEE Report and receive assurance	Written	Director of Nursing and Midwifery	1150 10mins		
217	Performance Report period 4, 2016/17	Review the latest Trust performance report and receive assurance	Written	Associate Director of Operations	1200 10mins	Well Led Staffing	3a
218	Finance Report period 4, 2016/17	To note the current status of the Trusts financial position	Written	Director of Finance	1210 10mins	Well Led	5a,b,c,d,e

Item no.	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard	BAF Risk
TRUST STRATEGY							
219	Future Generations Update	To brief the Board on progress and risks	Verbal	Chief Executive	1220 10mins	Well Led	Strategic aim
BOARD GOVERNANCE							
220	Board Assurance Framework	To review and note the current risks not being able to manage at a service level	Written	Trust Secretary	1230 10mins	Well Led	Strategic aim
221	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair		Well Led	-
HOUSEKEEPING							
222	Any other business	Consider any urgent items of other business	Verbal	Chair	1240 10mins	-	-
223	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 7 October 2016

Meeting to end at 1245

1245-1300 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

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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16/207

Board Agenda item

Board of Directors

Minutes of the meeting of the Board of Directors
held public on Friday 1 July 2016 at 1330 hrs
in the Boardroom, Liverpool Women's Hospital, Crown Street

PRESENT

Mr Robert Clarke	Chair
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 Jeff Johnston	Associate Director of Operations
Mr Colin Reid	Trust Secretary

APOLOGIES

Mr Ian Haythornthwaite	Non-Executive Director/Vice Chair
Mr Phil Huggon	Non-Executive Director

Thank You
Before the meeting opened formally the Board expressed its thanks to Mr Robert Kingston and Mr Geoff Shaw who were retiring from the Trust.

166 **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

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

168 **Annual Assurance on end of life care**

The Director of Nursing and Midwifery introduced Chris Webster, Macmillan CNS and Lead cancer nurse and Dr Leslie Allsopp palliative care consultant who had been instrumental in developing with

their teams a high quality consistent care within the Trust following the national reviews.

Chris Webster and Dr Leslie Allsopp present the report and reported that the annual report sought to provide assurance of the delivery of a consistently high standard of service provision and explained the processes undertaken during the year that included a retrospective audit, survey's sent to bereaved relatives, staff education and 1:1 buddying support. In response to a question from the Medical Director regarding interest in the process adopted by the Trust from other organisations, Chris Webster advised that the Trust was linked to palliative heath care – North West Coast and through hospice and community care in the locality and learnings were shared.

Referring to the two areas that the CQC felt improvement could be made following the February inspection, both had been reviewed and in the case of the; Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) cases, in those instances it was felt that nothing would have been done differently. Whilst in the case of Advanced Care Planning, the Specialist Palliative Care Team (SPCT) had adopted the NHS Advanced Care Planning documentation. This was currently being rolled out across the Trust and was supported by a programme of education relating to its use. The Board noted that the documentation was in use across the Trust from the end of June 2016.

The Medical Director thought that the work being done in this area was brilliant and the report highlighted clearly the strides the Trust had made following the national reviews. He suggested that as part of any review process there should be some peer reviews to reflect on how well the Trust was performing against best practice and asked whether such a peer review could be included within the work plan to obtain additional assurances.

The Board noted that the service had undertaken regular audits of their service, review of experience and review of compliance with NICE recommendations as part of their annual work plan and to provide assurance of the quality and consistency of the care received and where areas for improvement had been identified plans had been discussed and agreed with the team, and actioned accordingly. It was further noted that following recommendations from the CQC within their report, appropriate actions had been taken to make improvements where required.

The Board was therefore assured that high quality consistent care was being provided by the Trust and thanked Chris Webster and Dr Leslie Allsopp and the palliative care team.

169 Minutes of previous meeting held on Friday 3 June 2016

The minutes of the meeting held on 3 June 2016 was approved, subject to typographical amendments

170 Matters arising and action log.

The Board noted that all actions were either complete or on the agenda.

171 Chair's Report

The Chair provided a brief verbal report:

Volunteers Week: The Chair advised that he had attended an event for volunteers' that was also attended by the Mayor. He thanked all volunteers for their hard work and dedication in supporting the Trust in assisting patients and patients' friends and family. The Chair advised that the event was very humbling, hearing the reasons why people volunteer and asked that the Director of Workforce and Marketing, on behalf of the Board write to the volunteer manager thanking all volunteers for their valued contribution, hard work and dedication.

Stakeholder Meeting: The Chair advised that he had visited the vice chancellors of both the University

of Liverpool and John Moore's to introduce himself and to discuss the shared needs of the Trust and that of each university.

Council of Governors Meeting 20 July 2016: the Chair reminded the Board that the next Council of Governors meeting was due to be held on 20 July 2016.

The Board noted the Chair's update report.

172 Chief Executive's report

The Chief Executive advised that she had nothing to add to that already included on the agenda.

173 Chair's Report from the Finance, Performance and Business Development (FPBD) Committee held on 20 June 2016

The Chair advised that he had been discussing future reporting from the Board Committees with the Trust Secretary and also the structure of the meeting schedule. He explained that it was important that the meetings are held within timeframes that allowed for good and relevant reporting to the Board and that in reporting assurance was being given to the Board on the work of the Committee. The Chair advised that as the meeting dates for this financial year was already in place he did not propose to make any changes to the schedule of meetings until 2017/18. He did however feel that there was opportunity to look at Board Committee reporting to the Board and this should be completed by end of October 2016. This would be undertaken by the Trust Secretary with the Chair of the Committees and Executive leads as soon as practical.

Jo Moore, Chair of the FPBD Committee presented her Chair report from the meeting of the FPBD Committee on 20 June 2016. She advised on the items discussed and reported that as the Performance Report and the Finance Report were to be reported later in the meeting she had not duplicated what would be presented under those agenda items.

Jo Moore advised that the Committee had challenged the team on the delivery of the cost improvement plan and had also received and discussed the MOU for the proposed Joint Venture with Liverpool Clinical Laboratories for genetic services. She advised that this item was put on hold following the refusal by LCL to agree to price reductions on the pathology contract and the matter had been escalated to the CEO to consider how best to move the matter forward. The Associate Director of Operations provided a brief explanation for the joint venture which would provide a much better clinical service for patients.

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

174 Chair's Report from the Putting People First (PPF) Committee held on 17 June 2016 and annual Report 2015/16

Tony Okotie, Chair of PPF Committee, presented his report on the work of the Committee and advised that he and the non-executive directors on the Committee had found the use of deep dives and having staff attend the meeting to talk about the challenges they were facing, very good, giving a clearer understanding of the issues being faced by the Trust. He felt that all Board committees should include such items on their agenda.

Tony Okotie referred to his report and advised that the Committee had discussed the position of the Neonatal workforce. He explained that a deep dive, presented by the senior management team, into neonatal services workforce risks had identified an association with the recruitment of neonatal staff, the national shortage of neonatal staff, a high level of maternity leave and funding of the service from NHS England's specialist commissioned service. He advised that the Committee had heard that

actions were being taken to address the immediate pressures in the system and the longer term negotiations with NHS England. The issues surrounding the impact of cot closures on maternity, such as transfers/delayed procedures, had been referred to GACA. The Associate Director of Operations reported that the Trust, taking account of the risks reported, had recruited twelve trainees, seven of which were already qualified. These had been recruited from within the neonatal network and from Alder Hey. He advised that getting the recruitment right for the Trust could create problems elsewhere within the network due to shortages of available neonatal nursing staff.

The Director of Workforce and Marketing advised that the Annual Report of the 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.

The Chair thanked Tony Okotie for his verbal report which was noted.

175 Board Committee Terms of Reference Review

The Trust Secretary presented the revised terms of referee of the Audit Committee, the FPBD Committee and the PPF Committee. He advised that each Committee had reviewed the terms of reference ad were presented for approval of the Board. The Governance and Clinical Assurance (GACA) Committee terms of reference would be presented to the Board once it had held a GACA workshop that was being put in place to review the work of the Committee.

The Chair referred to the role of the FPBD and in particular that it authorised on behalf of the Board the Monitor Quarterly returns and asked the Board to consider whether this was appropriate. Tony Okotie felt that this should be a matter for the Board to approve and that it went to the hub of the earlier discussion that the Board and Committee schedule needed to be reviewed to allow for such approval to be obtained if it was deemed appropriate. The Board noted that until the meeting schedule was reviewed and changed, authority would remain with the FPBD.

The Board approved the terms of reference of the committees as presented.

176 Quality, Operational Performance report

The Associate Director of Operations presented the Performance Dashboard. He advised that there was an error on the dashboard relating to the financial KPIs, stating that the KPI for "Actual Surplus/Deficit (YTD)" was incorrectly coloured red when it should be reported as green, given the actual deficit was less than the planned deficit.

The Associate Director of Operations referred to the section that identified those KPIs that the Trust was not achieving and drew the Board attention to the "Six Week Wait for Diagnostic Test". He explained that this was due to a long terms sickness absence of a key member of staff. The delays impacted on patient experience but were not resulting putting patients at risk. The staffing issues had now been addressed and his expectation was that the KPI should return to green. The other KPI that he wanted to draw to the Board attention was the "Maternity Triage within 30 minutes" which was at 89% against a target of >= 95%. He advised that the Trust had breached this KPI for 5 consecutive months and changes in shift leadership within Triage had been made to manage the process would bring the KPI back on track.

The Chair referred to his attendance at GACA in May and the discussion surrounding delivery against the C-section KPIs and asked what was being done to mitigate this. The Medical Director advised that the Trust had, to some extent, set itself up to fail with theses KPIs. He explained that the whole suite of KPIs needed to be reviewed, with the C-section KPIs, so that the Trust was measured against quality standards (identified by NICE) as relevant KPIs that the Trust should be measured against. He went on to report that there needed to be greater challenge against the C-section KPIs. Susan Milner felt that it was important that from a 'public interest' point of view the Trust should not be

medicalising birth which the C-section KPIs seem to be doing. The Medical Director agreed with the comment and felt that better ways of measuring performance was needed, he advised that the C-section rates were a very blunt tool and needed to look at other identifiable KPIs that gave a better understanding of outcomes. Associate Director of Operations agreed with the Medical Director and advised that there was a need to challenge the commissioners what KPIs the Trust should be measured against; referring to the NICE guidance which sets out what the commissioners should be asking.

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

177 Financial Report & Dashboard Period 12

The Director of Finance presented the Finance Report and financial dashboard for month 2, 2016/17 and reported that Trust was reporting a monthly deficit of £0.678m against a deficit plan of £0.724 which was a positive variance of £0.046m for the month. Cumulatively the Trust was ahead of plan by £0.059m and achieved a Financial Sustainability Risk Rating (FSRR) of 2 against a plan of 2.

Tony Okotie referred to pay costs that were below budget and sought assurance that pay costs were being managed appropriately. The Director of Finance advised that all vacancies were reviewed by the Executive team who provide challenge on any request and if approved were done so on an individual basis.

David Astley referred to the slippage in delivery of the CIP for the year and asked what mitigations were in place to put delivery back on track. In response the Director of Finance reported that there were contingencies in place to bring in line CIP delivery and was confident that the Trust would deliver its planned deficit at year end. The Chief Executive supplemented the response and advised that a process of additional challenge and scrutiny had been put in place by the Executive, who on a bi weekly basis reviews all CIPs and this would be fed back into the FPBD.

Ian Knight asked when the Board would be reviewing the financial plan for 2017/18, the Director of Finance advised that the Trust had provided a 5 year plan that include the deficit for 2017/18, she explained that under NHSI process the Trust would be required to submit its annual plan in the fourth quarter of 2016/17, and therefore the Board would start to review the plan as early as October/November 2016. The Chief Executive advised that the headline deficit would be identified in January 2017 and that NHSI would be fully aware of the Trust's financial position as part of the monthly reporting process.

In response to a question on the pausing of Capital expenditure, the Director of Finance advised that any capital expenditure that was essential to patient safety would go ahead.

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

[Jo Moore left the meeting.]

178 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 first stage of the NHS England assurance process had concluded. She advised that the process was in a pre-consultation period that will take the process into a public consultation in the autumn.

The Chief Executive reminded the Board of the dates of the public engagement as part of the pre consultation process and asked that all Board members try and attend at least one of the meetings. David Astley advised that his recent visit to gynaecology services had been very enlightening and was

pleased that staff was fully engaged in the current options appraisal, which gave him assurance of what he was hearing at the Board. The Chief Executive advised that the staff had been fundamental over the last few years and had been at the forefront of the FG strategy.

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

179 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 recognised that the workshop had been arranged to review the Trust's risk management processes and in particular the risk appetite of the Board and a review of the BAF to make sure it was still relevant.

The Trust Secretary referring to the Board paper received agreement that the BAF would be reviewed by the Board and its committees as set out in the risk management process. The Chair noting that a Board workshop had been arranged for 7 July 2016 agreed to review the BAF's appropriateness in light of the changing landscape.

The Board noted the content of the BAF.

180 Review of risk impacts of items discussed

The Board noted the risks had been discussed. It reported the need for the FPBD to review the risk if non delivery of CIP.

181 Any other business

The Board congratulated Angela Douglas on receiving a MBE for for services to research and student mentoring.

The Board received an update from the Chair on his visit with the University of Liverpool at which he was introduced the president of the student union who would be contacting the Trust on how the student union could support the Trust.

182 Review of meeting

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

Date and time of next meeting

TBC

Liverpool Women's NHS Foundation Trust

16/208

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	To be reported under this agenda item.
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	On Target: Reported in the Board Assurance Framework paper. The FPBD and GACA have reviewed both the Appetite Statement and the Risks. PPF will undertake the review at its meeting in September.

Agenda item no:	16/210

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

Internal compliance process planned for December 2016: GACA have been leading the Trust's plans to ensure that all services run in accordance with both the CQC's Key Lines of Enquiry and the Fundamental Standards, which set in law the minimum requirements acceptable by the regulatory bodies. On a bi-annual basis the Trust has therefore committed to running an exercise where teams of staff conduct numerous audits across the entirety of the Trust as a mock inspection. The first of these exercises took place in June and a second is now prepared for the week of 12 December.

Training for this exercise will be provided at the Board of Directors meeting on 4 November. Board members will then be expected to attend a briefing session led by the CEO on Monday 12 December at 9am in the Blair Bell Lecture Theatre. The exercise will then run on 12, 13 and 14 December and cover all areas of the Trust with Board participation in at least one day required. The initial results of the inspection will be fed back by the CEO as part of the GREAT Day from 9am on Friday 16 December.

SECTION B - LOCAL

Health Education England : Dr Jane Mamelok, currently Deputy Postgraduate Dean (Primary Care and Public Health) and Director of Postgraduate GP Education (NW) has been appointed to the HEE (NW) Postgraduate Dean role, and will commence in post from the beginning of October after Professor Jacky Hayden's retirement.

Public Health England - 2016/17 Seasonal influenza Vaccination Campaign: All NHS Trust have been asked to nominate a director and operational lead for the 2016/17 campaign. The Lead Director is the Director of Nursing and Midwifery and the Operational Lead is Gill Curry, Occupational Health Manager.

SECTION C – NATIONAL

Royal College of Physicians Northern Headquarters: Liverpool has been chosen as the new Northern headquarters for one of the world's most renowned medical institutions. The city beat off Manchester and Leeds to host the historic institution's first centre of excellence outside of London which is expected to create 100 jobs. The new northern HQ will be built in the Knowledge Quarter, near the old Archbishop Blanch site, becoming the first tenant of the £1bn scheme to establish a world leading medical and scientific research hub.

Junior Doctors Contract: In July, junior doctors and medical students across England voted to reject the Government's proposed new contract. The details of the proposed new terms and conditions for junior doctors were outlined following ACAS talks between the BMA and the Government in May, and after a contract dispute in which junior doctors in England took industrial action five times.

Junior doctors in England voted in a referendum on whether or not to accept the contract following a series of more than 130 roadshows that took place across England explaining the terms and conditions of the deal. With a turnout of 68 per cent, around 37,000 junior doctors and medical students, 42 per cent voted in favour of the contract, while 58 per cent voted against.

Despite some last-minute movement from Health Education England on whistleblowing protections, and from NHS leaders with regard to the role of the Guardian of Safe Working, the Government has remained silent on the critical areas of concern.

The Junior Doctors Committee (JDC) Executive has made a formal request for a special meeting of the BMA Council to authorise a rolling programme of escalated industrial action beginning in early September. At this stage, no formal notice has been given in this regard.

Agenda item no:	16/212

Meeting:	Executive committee

Date:	2 September 2016

Title:	2016/17 Emergency Preparedness, Resilience and Response (EPRR) Assurance

Report to be considered in public or private?	Public

Purpose - what question does this report seek to answer?	To inform the committee of the required assurance relating to EPRR Core Standards 2016/17

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

Reference/s:	NHS EPRR Core Standards 2016/17

Resource impact:	

What action is required at this meeting?	That the Board note the time frames for the delivery of the 2016-17 EPRR assurance process and support the actions required. The Board approve the statement of compliance at Appendix 2.

Presented by:	Jeff Johnson, Associate Director of Operations

Prepared by:	Lisa Murphy Resilience Lead/LSMS

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	
To deliver the best possible experience for patients and staff	

Other:			
Monitor compliance		Equality and diversity	
NHS constitution	x	Integrated business plan	

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

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2016/17

1. Introduction and summary

On an annual basis the Trust is required to undertake an EPRR assurance process. NHS England will lead this process via Local Health Resilience Partnership (LHRP) in order to seek assurance that NHS organisations are prepared to respond to emergencies, and are resilient in relation to continuing to provide safe patient care and are compliant with NHS EPRR Core Standards for 2016/17.

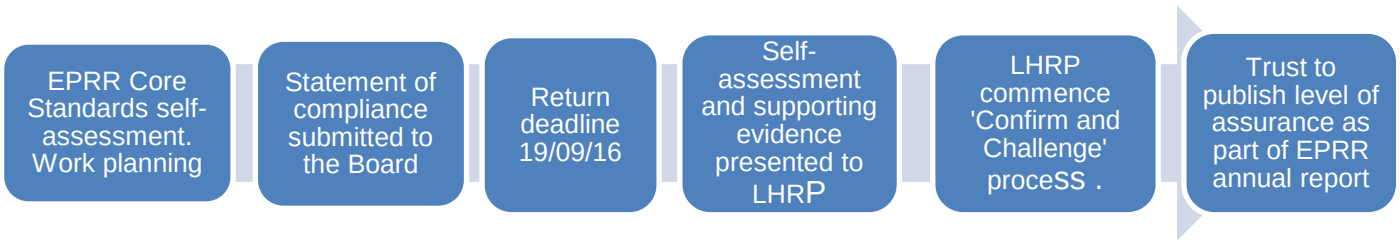
1. Actions

The Trust is required to undertake a self-assessment against the relevant individual core standards and rate our compliance. These individual ratings will then inform the overall organisational rating of compliance and preparedness.

Once this process has taken place the Trust is expected to take a statement of compliance to the Board members. This, along with the Core Standards assurance ratings and action plan will then form the submission to the Clinical Commissioning Group (CCG) and LHRP. The LHRP will then undertake a formal calibration process via a 'confirm and challenge' meeting with the Trust.

2. Assurance Process

The process of assurance is outlined below:



This will process will be concluded by April 2017

3. Assurance Deep dive

This year's EPRR assurance 'deep dive' topic is Business Continuity with an emphasis on fuel. The fuel emphasis this year is designed to support a national cross government initiative which is occurring across a number of other local services and including Local Resilience Forum's.

4. Organisational Assurance Ratings

The Trust will be expected to state an overall assurance rating as to whether we are fully, substantially, partially or non-compliant with the NHS EPRR Core Standards. The definitions of these ratings have been amended for the 2016/17 process and are detailed below:

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

2. Key themes

This report details the Trust's compliance against the NHS Emergency Preparedness Resilience and Response Core standards. The individual ratings for each standard will inform the overall organisational rating of compliance and preparedness to respond to emergencies, and is resilient in relation to continuing to provide safe patient care.

The Core Standards assurance ratings and action plan will form the Trust's submission to the Clinical Commissioning Group (CCG) and Local Health Resilience Partnership (LHRP). The LHRP will then undertake a formal calibration process via a 'confirm and challenge' meeting with the Trust. The expectation is that a statement of compliance will then be presented to the Board of Directors.

The self-assessment in appendix 1highlights the required work to mitigate against identified risks and incorporate the lessons identified relating to EPRR:

- An annual report and work programme needs to be developed that details lessons identified from exercises and live events.
- The Board and/or Governing body needs to receive an annual EPRR report.
- Resources need to be made available to meet the requirements of the cord standards as required.
- Trust wide BCM plan is under review and needs approval by all Clinical and Support services
- An evacuation plan needs to be developed to identify locations which patients can be transferred to if there is an incident that requires an evacuation
- Trust wide BCM plan needs to be developed from clinical and support service plans.
- VIP policy needs to be transferred into SOP template as requested by the Policy committee
- Executive Directors who are on-call need to have completed 'Strategic Leadership in a Crisis' course.
- Unify2 Sitrep reporting process needs to be amended in the MIR plan.
- More training is needed for staff that have roles in EPRR. Exercise planned for September 2016 on a bomb threat will test the newly developed bomb threat SOP and aid memoir.
- Trust needs to participate in multi-agency exercises
- On-call directors and managers involved in multi-agency exercises need to maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.

3. Conclusion

Though some work has been done towards addressing actions there is still more work to be done to achieve full compliance.

4. Recommendations

That the Board note the timeframes for the delivery of the 2016-17 EPRR assurance process and support the actions required. The Board complete the statement of compliance and the action plan to improve compliance.

	Core standard	Trust Evidence of Assurance	RAG	Action to be taken	Lead	Time scale
Governance						
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)	• Jeff Johnston is the Accountable Emergency Officer (AEO) and a member of the Executive Board of Directors. • Lisa Murphy (Resilience Lead/LSMS) is the appointing an Emergency Preparedness, Resilience and Response practitioner (EPRR) who has completed the Health Emergency Planning Diploma and is a Business Continuity Management (BCM) practitioner who can demonstrate an in depth understanding of emergency planning and BCM principles.	**Compliant**			
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	• The 2015-16 work plan was received by GACA in September 2015. This included details of training, exercises and past incident. This report was presented by the AEO.	**Partially Compliant**	• The Trust needs to develop a work programme for 2016-17 to mitigate against identified risks and incorporate the lessons identified relating to EPRR.	Resilience Lead/LSMS	Sep-16
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	• EPRR Strategy has been developed which details the process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible.	**Compliant**			
4	The AEO ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	• The 2015 EPRR annual report details the lessons identified from exercises and live events. This was presented to GACA by the AEO.	**Partially Compliant**	• 2016 EPRR annual report needs to be developed which details lessons identified from exercises and live events. • The Board and/or Governing body needs to receive this report, annually. • Resources need to be made available to meet the requirements of the cord standards as required.	Resilience Lead/LSMS AEO AEO	Sep-16 Sep-16 As required

	Core standard	Trust Evidence of Assurance	RAG	Action to be taken	Lead	Time scale
Duty to Assess Risk						
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	• EPRR risks are detailed on the corporate risk register which are reviewed by the Resilience lead at least annually. • Any new or emerging threats and hazards are risk assessed and added to the risk register as appropriate.	**Compliant**			
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	The risks on the Trust's risk register reflect the risks on the Community risk register including: Severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); staff absence (including industrial action); Fuel shortages; surges and escalation of activity; IT & communications failure; loss of utilities; responding to a major incident; mass casualties.	**Compliant**			
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Were relevant risks are shared with partners via the LHRP that the AEO attends and the HRP attended by the Resilience lead/LSMS	**Compliant**			
Duty to maintain BCM & MIR plans						
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	**Compliant**			
		Corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	**Partially compliant**	Trust wide BCM plan is under review and needs approval by all Clinical and Support services	Resilience lead/LSMS	Sep-16
		HAZMAT/ CBRN - see separate checklist on tab overleaf	**Compliant**			
		Severe Weather (heatwave, flooding, snow and cold weather)	**Compliant**			
		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	**Compliant**			
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	**Compliant**			
		Fuel Disruption	**Compliant**			

	Core standard	Trust Evidence of Assurance	RAG	Action to be taken	Lead	Time scale
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	**Compliant**			
		Infectious Disease Outbreak	**Compliant**			
		Lockdown	**Compliant**			
		Evacuation	**Partially compliant**	An evacuation plan needs to be developed to identify locations which patients can be transferred to if there is an incident that requires an evacuation	Resilience lead/LSMS	Oct-16
		Utilities, IT and Telecommunications Failure	**Compliant**			
		Excess Deaths/ Mass Fatalities	**Compliant**			
		Mass Casualties	**Compliant**			
		Having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab	**N/A**			
		Firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab	**N/A**			
	Ensure that plans are prepared in line with current guidance and good practice which includes:	There is evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions:• Being able to provide evidence of an approval process for EPRR plans and documents• Asking peers to review and comment on your plans via consultation• Using identified good practice examples to develop emergency plans• Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down• Version control and change process controls • List of contributors • References and list of sources• Explain how to support patients, staff and relatives before, during and after an incident	**Compliant**			

	Core standard	Trust Evidence of Assurance	RAG	Action to be taken	Lead	Time scale
10	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	• Executive Director On call are in place and include 24-hour arrangements for alerting managers and other key staff.	**Compliant**			
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Clinical and support service BCM plans have identified their critical activities	**Partially compliant**	Trust wide BCM plan is being developed from clinical and support service plans	**Resilience lead/ LSMS**	Sep-16
12	Arrangements explain how VIP and/or high profile patients will be managed.	VIP plan developed in line with relevant guidance	**Partially compliant**	VIP policy needs to be transferred into SOP template as requested by the Policy committee	**Resilience lead/LSMS**	Aug-16
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content	EPRR strategy and plans have been developed with engagement and co-operation of members of the EPRR committee and moving forward EPRR is an agenda item at the Safety Senate.	**Compliant**			
14	Arrangements include a debrief process so as to identify learning and inform future arrangements	Following live incidents and exercises a hot debrief is carried out at the end of the event and final report is presented to the Board. Debriefs are shard with members of the LHRP & LRF	**Compliant**			
Command and Control (C2)						

	Core standard	Trust Evidence of Assurance	RAG	Action to be taken	Lead	Time scale
15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	The single point of contact 24/7 is the Executive Director on call who can be contacted by switchboard (0151 702 4125). All the on call team have access to the major incident email account for all email correspondence with Gold command majorincident @lwh.nhs.uk	**Compliant**			
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	Executive Directors have had internal training on escalation in the event of a major incident (Silver)	**Partially compliant**	Executive Directors who are on-call need to have completed 'Strategic Leadership in a Crisis' course.	Resilience lead/LSMS	Dec-16
17	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	The Incident Control Centre (ICC) operating procedures help manage the ICC (for example, set-up, contact lists etc.), The are electronic and in paper for in the Battle box) with contact details for all staff involved. Duties are detailed on action cards. Mutual agreements/arrangements are in place with AHCH to utilise each other's ICC rooms if our own are not available.	**Compliant**			
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.	Decision log book and loggist book are available in the Battle box	**Compliant**			
19	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.	Sitrep process is detailed in the Major incident Response Plan. However the process has now changed and is reported via Unify 2.	**Partially compliant**	Unify2 Sitrep reporting process needs to be amended in the MIR plan.	Resilience lead/LSMS	Oct-16

	Core standard	Trust Evidence of Assurance	RAG	Action to be taken	Lead	Time scale
20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.		**N/A**			
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;		**N/A**			
Duty to communicate with the public						

	Core standard	Trust Evidence of Assurance	RAG	Action to be taken	Lead	Time scale
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Emergency communications response arrangements in place. majorincident@lwh.nhs.ukStaff EPRR leaflets•The Comms team communicate with the public in an emergency via the website and social media•Lessons identified from previous exercises and events are used to inform the development of future campaigns eg junior doctor strikesUnify 2 system used for communicating normal business which is utilised for Sitrep reporting. Comms team have reviewed their action card in the MIR plan. Comms team confirmed that they have a comms strategy for communicating with the public in an emergency situation.	**Compliant**			
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures	IT have a disaster recovery plan and process in place if IT and phone systems go down. The plan has been tested in several live events.	**Compliant**			
Information Sharing – mandatory requirements						
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	• The Trust shares information via the LHRP & LRF and other groups.	**Compliant**			
Co-operation						

	Core standard	Trust Evidence of Assurance	RAG	Action to be taken	Lead	Time scale
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)	• Rreceipt of minutes from relevant LRF meetings, and attend when possible. Active engagement and co-coperation was demonstrated while th erecnet junior doctor industrial action took place. •Execurive attendance at the Local Health Resilience Partnership meetings • Mutual aid agreements in place via LHRP • lessons identified from the Trust events and incidents and those learned from collaboration with other responders and the LRF and the LHRP. • List of contacts among both Cat. 1 and Cat 2. responders with in the LRF. Completion of SITREPs, cascading of information and prioritising of services eg junior doctor strikes	**Compliant**			
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		**Compliant**			
27	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.		**Compliant**			
28	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		**N/A**			
29	Arrangements outline the procedure for responding to incidents which affect two or more regions.		**N/A**			
30	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties		**Compliant**			
31	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared		**N/A**			

	Core standard	Trust Evidence of Assurance	RAG	Action to be taken	Lead	Time scale
32	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months		**N/A**			
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level					
Training And Exercising						
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Lessons taken from all resilience activities and using the LRF and the LHRP network meetings.Training and briefing programme for staff and key stakeholders are given to staff involved in exercises• The reports demonstrate lessons identified in exercises and emergencies and business continuity incidents	**Partially compliant**	More training is needed for staff that have roles in EPRR. Some staff are not clear what their roles are in plans.	Resilience lead/LSMS	Oct 16

	Core standard	Trust Evidence of Assurance	RAG	Action to be taken	Lead	Time scale
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.		**Partially compliant**	Exercise planned for September 2016 on a bomb threat will test the newly developed bomb threat SOP and aid memoir. The escalation process will also be tested . Programme and schedule for future updates of training and exercising needs to be developed. Communications exercise every 6 months, table top exercise annually and live exercise at least every three years	Resilience lead/LSMS	Aug-16
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		**Partially compliant**	Trust needs to participate in mulltiagency exercises	Resilience lead/LSMS	TBC

	Core standard	Trust Evidence of Assurance	RAG	Action to be taken	Lead	Time scale
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		**Partially compliant**	On-call directors and managers involved in multi-agency exercises need to maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.	Executive directors and managers on call	Dec-16 and ongoing

Appendix 2

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2016-17

STATEMENT OF COMPLIANCE

The Liverpool Women's NHS Foundation Trust has undertaken a self-assessment against the NHS England Core Standards for EPRR (v4.0).

Following self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating **Partial** compliance against the EPRR Core Standards.

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

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Red**[1]	Standards rated as **Amber**[2]	Standards rated as **Green**[3]
31	0	8	23
Acute providers:53 Specialist providers: 44 Community providers: 44 Mental health providers: 44 CCGs: 35	[1] *Not complied with and not in an EPRR work plan for the next 12 months*	[2] *Not complied with but evidence of progress and in an EPRR work plan for the next 12 months*	[3] *Fully complied with*

Where areas require further action, this is detailed in the attached *EPRR Core Standards Improvement Plan* and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the above level of compliance with the EPRR Core Standards has been or will be confirmed to the organisation's board / governing body.

_____

Signed by the organisation's Accountable Emergency Officer

_____ _____

Date of board / governing body meeting *Date signed*

Agenda item no:	16/216

Meeting:	Board of Directors

Date:	2 September 2016

Title:	Safety, Effectiveness and Experience (SEE) Report

Report to be considered in public or private?	Public

Where else has this report been considered and when?	Safety Senate – May 2016 Governance and Clinical Assurance Committee – July 2016

Reference/s:	-

Resource impact:	None

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

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

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

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

Presented by:	Dianne Brown, Director of Nursing & Midwifery

Prepared by:	Governance Team

This report covers (tick all that apply):

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

Other:	

Monitor compliance	✓	Equality and diversity	
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 Introduction and Summary

This report provides a comprehensive update on performance, achievements and concerns across the Trust.

2 Key Themes

Key risks identified are:

- £822,000 has been paid in damages this quarter as a result of 7 settled claims against the Trust. Because of the historic nature of many claims the Trust receives there is often difficulty obtaining details of any incident investigation as the Trust was not recording its incident investigations electronically prior to 2006. Defending the Trust appropriately can be difficult as locating historic records, identifying historic best-practice and preparing material to assist in the investigation of claims regarding historic care places a considerable burden on both the Governance Team and on clinicians and is not always possible.
- The Friends & Family Response Rate has fallen this quarter, particularly within the 'Antenatal Care' and 'Birth' categories.
- There has been an increase in the percentage of NICE guidelines breaching their initial assessment time. This has been raised at the Trust's Effectiveness Senate with each guideline also being addressed on an individual basis.
- External Partnership working in Safeguarding. Currently due to the high number of performance data and audit requests from external Boards and provision of attendance and attendance at Child protection case conferences, LWFT are struggling to balance the demands. This has been raised to the CCG Chief Nurse at CQPG who has agreed to escalate through the external Boards and agree a way forward. This risk remains an ongoing issue and progress will be reported through the Hospital Safeguarding Board.

Key successes identified are:

- A continued increase in the level of reporting of incidents for this quarter. The latest NRLS reports puts us in the top quarter of reporters. NRLS report that organisations that report more incidents usually have a better and more effective safety culture.
- Sefton Council's Oversight and Scrutiny Committee visited the Trust on 24 March. Members commented how pleased they had been that they were given the opportunity to choose the areas to visit on the day and that because they therefore weren't expected by staff that probably gave a truer reflection of service areas. They also commented that the staff's passion for their jobs certainly came across.
- Further strong progress with safeguarding training, especially Levels 1 and 2 which saw a rise of 65% in one quarter across the whole Trust.

- Safeguarding have now completed the commissioned peer review of safeguarding services in Birmingham Women's NHS Foundation Trust and since Q3 have undertaken a further Safeguarding Peer Review of the Royal Liverpool and Broadgreen NHS Hospitals Trust.
- The Safeguarding Team have been recognised for the services to the Trust by winning the prestigious 'Dedicated to Excellence' Team of the Year Award.
- 0 staff days lost to sickness following RIDDOR incidents during this quarter

3 Conclusions

Triangulation of key themes identified in the report has established that:

- There was a lack of assurance from the internal audit of Pathology and Radiology Results. This has been followed by serious incidents highlighting the failings in the current processes. The local commissioning group are aware that the Trust has registered as a risk the lack of a robust process for reviewing images and are taking steps to address the recommendations made.

- The introduction of the new Trust Governance structure means key safety, effectiveness and experience themes are being discussed at dedicated Senates. GACA will be commissioning a deep dive into items of particular note picked up through this triangulation.

The Clinical Commissioning Group has viewed previous quarters' SEE reports. They felt a combined report in this format provided assurance and was suitable for submission as evidence for the Trust's quarterly Quality Schedule. The 2016-17 Quality Schedule negotiations did not see the hoped for reduction in the quantity of requested information.

4 Recommendations

It was agreed that following receipt of the SEE Report, GACA would commission a piece of work. It had been suggested when this report was viewed by the Safety Senate that GACA commissions a report on Erbs Palsy. GACA agreed to this recommendation. It is therefore recommended that the Board also support this report.

Liverpool Women's
NHS Foundation Trust

SEE Report
Quarter 4
January – March 2016

A comprehensive update on Safety, Effectiveness & Experience at Liverpool Women's

	Summary Description	2015/16				Narrative Summary
		Q1	Q2	Q3	Q4	
SAFE	Claims and Litigation	458	478	468	-	Number of open claims at the end of the quarter
		6	2	8	-	Number settled by Quarter
	Reports on Prevention of Future Deaths	0	0	0	0	Total issued following inquests held in the quarter
	Incidents: Patient	695	738	850	969	Total reported where a patient has been identified
	Staff	515	491	462	519	Total reported where staff have been named in the incident
	Visitor / Contractor / Member of Public	24	17	19	22	Total reported where a visitor / contractor / member of public is identified.
	RIDDOR reported incidents	1	0	1	0	Number of staff RIDDOR's reported
		86	88	36	0	Number of staff days lost to sickness following RIDDOR incident
		0	0	0	0	Number patient RIDDOR's reported
	StEIS	4	6	4	10	Number Serious incidents reported
		17	19	23	23	Number Serious incidents currently open of the system
	Never Events	1	1	0	0	Confirmed StEIS 'Never Events'
	CAS Alerts	21	40	38	20	Number of alerts issued in the quarter
		0	0	0	0	Number beyond closure date
	Safeguarding Vulnerable Adults	46	44	31	80	Number of Adult Safeguarding concern's referred (inc DV)
	Safeguarding Vulnerable Children	180	288	351	401	Number of Child Safeguarding concerns referred (inc DV)
	Domestic Abuse	170	156	142	197	Number of Domestic Abuse concerns referred
	Allegations against staff	1	0	0	2	Number of safeguarding allegations raised
	Number of MCA referrals	6	24	67	43	Number of referrals made
	Number of DoLs referrals	1	2	1	1	Number of referrals made
	Emergency Preparedness: unplanned events	0	1	0	0	Number of major or business continuity incidents
	Number of policies out of date	17	16	15	18	18 out of date - 10 currently out for consultation, 8 in process of being reviewed via author
	Infection Control; C-difficile	0	0	0	0	

	Summary Description	2015/16				Narrative Summary
		Q1	Q2	Q3	Q4	
EFFECTIVE	NICE	**28%**	**0%**	**0%**	**6%**	Percentage of Guidelines Breached
	Internal Audit	**-**	**-**	**-**	**78%**	Percentage of audits that provide assurance (from RSM annually)
	Clinical Audit	**25%**	**20%**	**14%**	**3%**	Percentage of completed audits that provide limited assurance (exc baseline audits)
	CQC Intelligence Monitoring Risks Identified	**1**	**-**	**-**	**-**	Number of red risks **(Indicator Retired by CQC)**
		3	**-**	**-**	**-**	Number of amber risks
EXPERIENCE	Complaints	**39**	**36**	**38**	**36**	Number of complaints received
		37	**34**	**26**	**35**	Number of Complaints due for response
		0	**7**	**0**	**2**	Number not responded to within timescale agreed divisionally
		0	**0**	**0**	**27**	Number of responses without an appropriate action plan
		122	**102**	**152**	**174**	Number of PALS contacts
	Friends and Family: Inpatient	**-**	**26% (95%)**	**17% (98%)**	**12% (99%)**	Response Rate (satisfaction rate)
	Friends and Family: A&E	**-**	**31% (97%)**	**37% (98%)**	**22% (99%)**	Response Rate (satisfaction rate)
	Friends and Family: Maternity	**-**	**4% (97%)**	**4% (99%)**	**0.91% (100%)**	Antenatal Care Response Rate (satisfaction rate)
		-	**5% (96%)**	**3% (97%)**	**0.53% (91%)**	Birth Response Rate (satisfaction rate)
		-	**12% (93%)**	**13% (98%)**	**2% (94%)**	Care on postnatal ward Response Rate (satisfaction rate)
		-	**1% (100%)**	**1% (86%)**	**1% (97%)**	Postnatal community provision Response Rate (satisfaction rate)
	Friends and Family: Staff	**-**	**-**	**-**	**80%**	Received once a year via the National Staff Survey
	Ombudsman	**1**	**1**	**1**	**1**	Complaint responses appealed to the Ombudsman

Executive Summary

The Q4 SEE report provides a comprehensive update on performance, achievements and concerns across the Trust.

Key risks identified are:

- £822,000 has been paid in damages this quarter as a result of 7 settled claims against the Trust. Because of the historic nature of many claims the Trust receives there is often difficulty obtaining details of any incident investigation as the Trust was not recording its incident investigations electronically prior to 2006. Defending the Trust appropriately can be difficult as locating historic records, identifying historic best-practice and preparing material to assist in the investigation of claims regarding historic care places a considerable burden on both the Governance Team and on clinicians and is not always possible.
- The Friends & Family Response Rate has fallen this quarter, particularly within the 'Antenatal Care' and 'Birth' categories.
- There has been an increase in the percentage of NICE guidelines breaching their initial assessment time. This has been raised at the Trust's Effectiveness Senate with each guideline also being addressed on an individual basis.
- External Partnership working in Safeguarding. Currently due to the high number of performance data and audit requests from external Boards and provision of attendance and attendance at Child protection case conferences, LWFT are struggling to balance the demands. This has been raised to the CCG Chief Nurse at CQPG who has agreed to escalate through the external Boards and agree a way forward. This risk remains an ongoing issue and progress will be reported through the Hospital Safeguarding Board.

Key successes identified are:

- A continued increase in the level of reporting of incidents for this quarter. The latest NRLS reports puts us in the top quarter of reporters. NRLS report that organisations that report more incidents usually have a better and more effective safety culture.
- Sefton Council's Oversight and Scrutiny Committee visited the Trust on 24 March. Members commented how pleased they had been that they were given the opportunity to choose the areas to visit on the day and that because they therefore weren't expected by staff that probably gave a truer reflection of service areas. They also commented that the staff's passion for their jobs certainly came across.
- Further strong progress with safeguarding training, especially Levels 1 and 2 which saw a rise of 65% in one quarter across the whole Trust.
- Safeguarding have now completed the commissioned peer review of safeguarding services in Birmingham Women's NHS Foundation Trust and since Q3 have undertaken a further Safeguarding Peer Review of the Royal Liverpool and Broadgreen NHS Hospitals Trust.
- The Safeguarding Team have been recognised for the services to the Trust by winning the prestigious 'Dedicated to Excellence' Team of the Year Award.
- 0 staff days lost to sickness following RIDDOR incidents during this quarter

Key themes identified from triangulation are:

- There was a lack of assurance from the internal audit of Pathology and Radiology Results. This has been followed by serious incidents highlighting the failings in the current processes. The local commissioning group are aware that the Trust has registered as a risk the lack of a robust process for reviewing images and are taking steps to address the recommendations made.

Contents

SAFE

Risk Escalation Monitoring Report

The Trust risk register currently comprises of 299 risks in Q4, an increase of 9 from previous Q3, as 34 have been added and 25 have been closed in the period. There are 268 service risks an increase of 8 from the previous report in Q3. 10 risks sit on the corporate register and are monitored by the Corporate Risk Committee on a bi-monthly basis, 24 risks are aligned to the Board Assurance Framework (BAF) with oversight by the Trust Board in accordance with the Risk Management Strategy.

This report provides details of any risks added, closed and risk score changed within the period. All BAF and corporate risks have an executive lead as the identified owner to ensure that the risks are mitigated.

Table 1 below details the distribution of Trust risks listed by Directorate.

There are 15 blanks are identified in the risk distribution by area, this is due to the risks not being allocated a specific area and is due to it relating to a Division. Certain registered risks, including the Strategic BAF risks, may not relate to a specific Area and is a Trust risk.

Table 1:

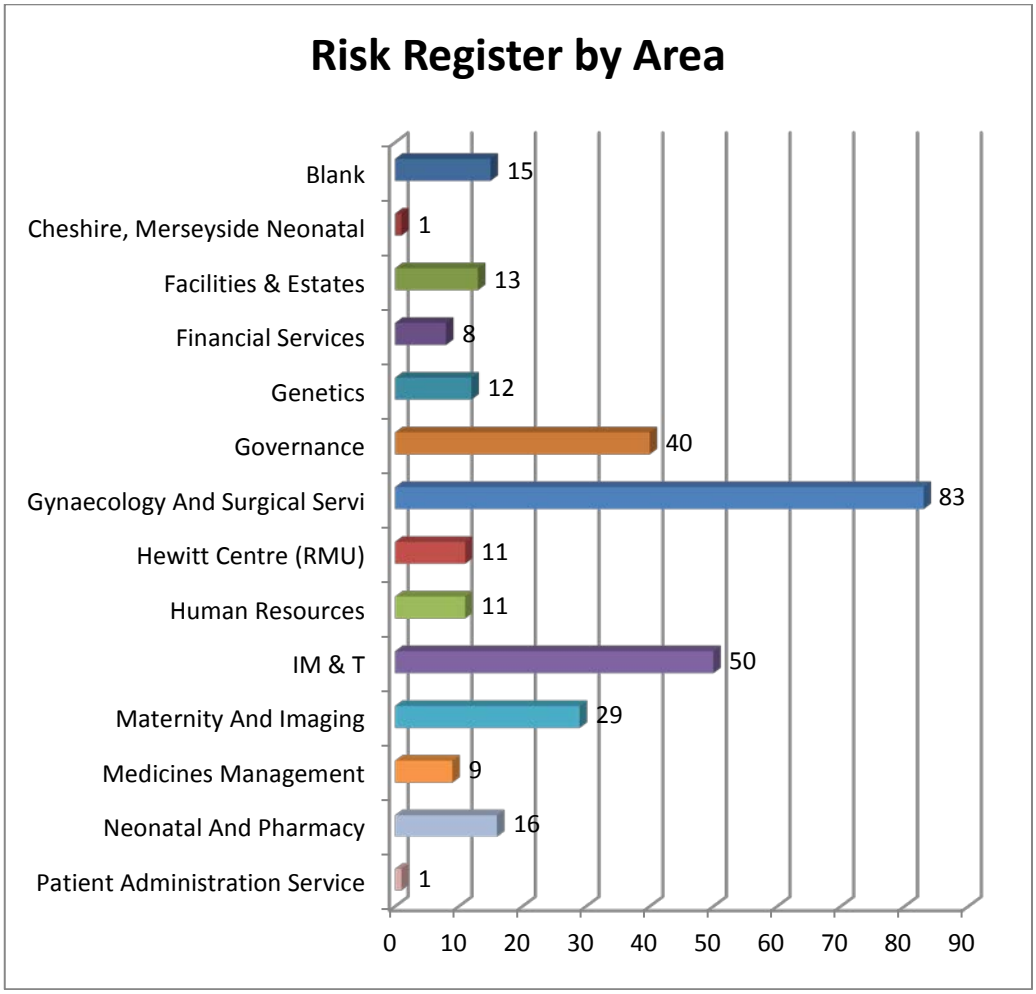


Table 2 details all Trust risks and their affiliated NPSA domains. The 'impact on patient safety' domain is the highest attributed domain with 130 risks.

Table 2

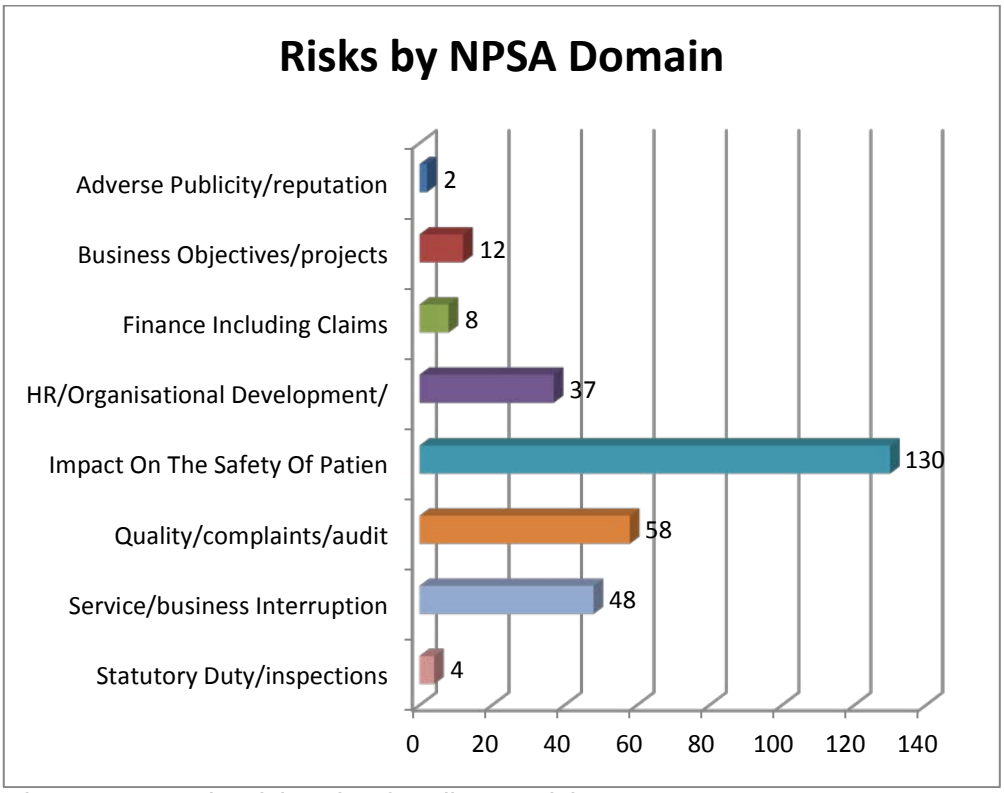


Table 3 demonstrates the risk rating for all Trust risks.

There are 125 (42%) risks of 299 which are scored as High and 125 (42%) of risks are moderate.

Table 3

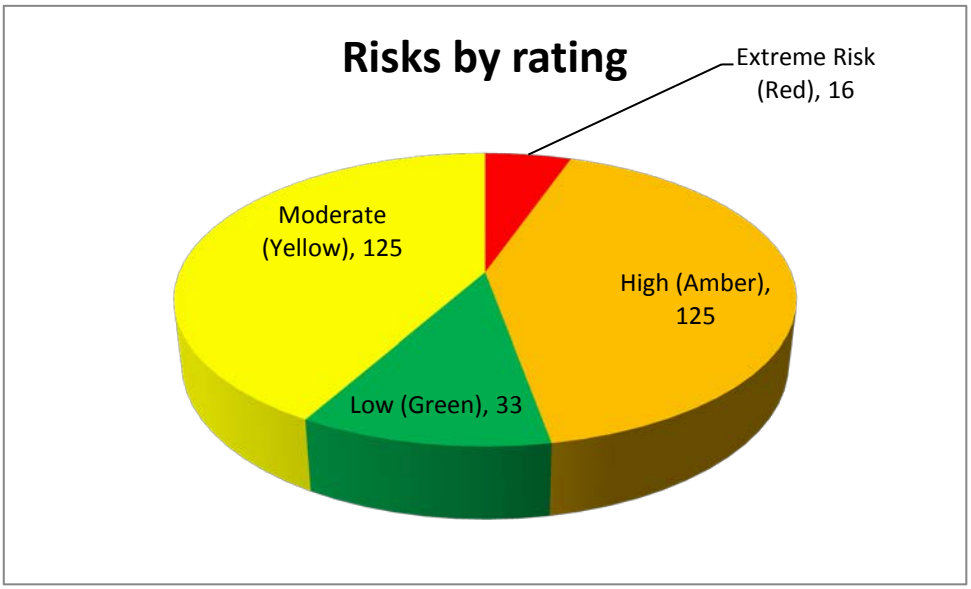


Table 4 shows there were 35 new risks added in Q4 15-16 showing the service to which the risk is aligned.

Table 4:

Risks added in Q4 2015-16		
Risk Register Type	**Directorate**	**Total**
Service	Cheshire, Merseyside Neonatal	1
Service	Genetics	4
Service	Governance	1
Service	Gynaecology And Surgical Service	11
Service	Hewitt Centre (RMU)	2
Service	IM & T	1
Service	Maternity And Imaging	7
Service	Neonatal And Pharmacy	1
Service	Trust	1
Corporate	Facilities & Estates	1
Corporate	Maternity And Imaging	1
Corporate	Trust	1
BAF	Neonatal And Pharmacy	1
BAF	Trust	1
TOTAL		**34**

Table 5 shows there were 25 closed risks on the risk register

Table 5:

Risk Register Type	Directorate	Total
Service	Cheshire, Merseyside Neonatal	1
Service	Facilities & Estates	8
Service	Gynaecology And Surgical Servi	5
Service	Human Resources	1
Service	IM & T	1
Service	Maternity And Imaging	2
Service	Neonatal And Pharmacy	3
Corporate	Trust	1
Corporate	Governance	2
BAF	Human Resources	1
TOTAL		**25**

There were 29 incidents that the risk score changed in the period, 19 risks reduced and 10 increased.

In the last quarter the Risk team has addressed the following issues raised in the last report:

Achieved:

- Revised the Risk Management Training presentation, separating it from trhe Health & Safety Training.
- Revised the Risk Management Training workbook to maintain parity with the face to face training.
- Included specifically in the revised training, the need for and correct way to identify persons involved within incident reports so as to maintain confidentiality in the narrative, but still enable support of the revalidation process for clinical staff..
- Created and submitted a Risk Actions report to the Corporate Risk Committee, this was welcomed and will become a regular report.

Recommendation(s)

- The Risk team have explored activating the current risk rating matrix as mandatory to ensure that all risks entered onto the risk register will always have a current risk score. Unfortunately, whilst the intention was to make the severity and the likelihood fields, which determine the risk score mandatory, it proved possible to make only one of these mandatory, this will not provide the functionality required. Liaison has been undertaken with the system provider who has identified the programing issue and will explore this as a potential development.
- To implement the risk escalation process within Ulysses risk management system, to reflect the escalation process in the Risk management strategy.
- The Risk Team promote the use of the actions facility within Ulysses to provide more robust assurance evidence of learning and responsive change from incidents and risks.

Incidents

Trust –Wide Incident Reporting Trends (All incident types)

In total 1087 incidents were reported in quarter 4 of 2015/16, compared to 1026 in Q3. The table below provides a summary of the total number of all reported incidents by service.

	Reporting Period 2015/16 Q4			
Directorate	**Jan**	**Feb**	**March**	**Total**
Women's and Children's Services				
Genetics	7	11	15	33
Gynaecology And Surgical Services	63	75	59	197
Anaesthesia	4	4	1	9
Catharine Suite	0	0	0	0
Hewitt Centre (RMU)	6	11	9	26
Maternity	154	184	204	542
Imaging	2	5	4	11
Neonatal	43	24	34	101
Pharmacy	0	1	2	3
Cheshire, Merseyside Neonatal Transport Team	10	14	13	37
Corporate Services				
Patient Administration Service	15	13	23	51
Facilities & Estates	8	8	11	27
Financial Services	0	2	0	2
Governance	1	2	3	6
Human Resources	1	0	0	1
IM & T	9	17	15	41
Monthly Totals	323	371	393	1087

Review of Q4 incident reporting trends has identified that:

The total number of incidents reported during 2015/16 Q4 was 1087 representing a 5.9% increase against 2015/16 Q3 which was 1026 reported incidents. At the time of writing this report (14/04/16) 149 incidents remain in the WHF for this reporting period awaiting review and action.
The Trust wide daily incident report generated from Ulysses continues to be monitored to identify rapidly any potential serious incidents.

The Trust wide Web Holding File daily reports generated from Ulysses continue to be circulated to managers. A weekly service specific Web Holding File report is also sent to the relevant managers to assist in timely review of incidents.
A web holding file report on the number of incidents managed and waiting to be merged by the risk team has been implemented to monitor the merging activity. This was instigated in September 2015 when the services had a drive to address the backlog of outstanding reviews, which created a sudden and significant rise in the number of incidents to be quality checked and merged. The report enabled the active management of this backlog, which has now been eliminated, with numbers being maintained at a level well within capacity.

Clinical Incidents Trends and Themes

The total number of reported clinical incidents affecting patients was 884**.** In the summary table on page 2 the number of incidents in which a patient has been identified is 1510. This can be explained by the fact that some clinical incidents do not include patient details and other clinical incidents include more than one patient. It has been recognised that some staff do not add patient details even though the incident involves a patient.

The risk team reminded staff of the importance of including patient details for incidents involving patients during the Ulysses Duty of Candour training sessions held throughout November 2015. Following this training the risk officers intend to produce a regular report that will identify which clinical incidents do not have patient details included.

The table below indicates the number of clinical incidents reported in the reporting time frame and the status of those incidents.

	January	February	March
Managed and Merged Incidents	268	276	293
Web Holding File:			
Completed by Managers	1	11*	11
Waiting for Managers Form	1	3	2
Under Review	3	6	9
Overall Total	**273**	**296**	**315**

*3 incidents were in the live system rather than WHF as a consequence of transfer.

The Top 3 reported **patient safety incidents** by category and area:

	Reporting Period 2015/16 Q4					
	Jan	**Feb**	**March**	**Total Number of Reported Clinical Incidents**	**Top 3 as a % of Reported Divisional Total**	**Top 3 as a % of Reported Corporate Total**
Women's and Children's Services						
Genetics						
Patient Records / Identification		2	1	3	20%	<1%
Investigations	1	2		3	20%	<1%
Equipment		2		2	13%	<1%
Gynaecology And Surgical Services						
Clinical Management	2	5	1	8	4.6%	<1%
Medication	1	1	6	8	4.6%	<1%
Patient Records / Identification	4	2	1	7	4%	<1%
Anaesthesia						
Communication		2		2	28.5%	<1%

	Reporting Period 2015/16 Q4					
	Jan	**Feb**	**March**	**Total Number of Reported Clinical Incidents**	**Top 3 as a % of Reported Divisional Total**	**Top 3 as a % of Reported Corporate Total**
Patient Records / Identification	2			2	28.5%	<1%
Catherine Suite						
	0	0	0			
Hewitt Centre (RMU)						
Clinical Management		3		3	21.4%	<1%
Staffing Levels		1	1	2	14.2%	<1%
Patient Records / Identification	1	1		2	14.2%	<1%
Maternity						
Medication	4	18	31	53	11.5%	6.2%
Admission / Discharge / Transfer	6	20	20	46	10%	5.3%
Clinical Management	11	4	14	29	6.3%	3.3%
Imaging						
Communication	1		2	3	60%	<1%
Patient Records / Identification			2	2	40%	<1%
Neonatal						
Medication	16	12	2	30	33%	3.5%
Admission / Discharge / Transfer	6	1	3	10	10.9%	1.1%
Equipment	3	4	3	10	10.9%	1.1%
Pharmacy						
Medication			2	2	66.6%	<1%
IT Problems		1		1	33.3%	<1%
Cheshire, Merseyside Neonatal Transport Service						
Ambulance Related	3	1		4	33.3%	<1%
Admission / Discharge / Transfer	2			2	16.6%	<1%
Equipment	2			2	16.6%	<1%
Corporate Services						
Booking, Scheduling And Administration						
Appointment Error	4	3	6	13	28.2%	1.5%
Communication	3	6		9	19.5%	1%
Patient Records / Identification			3	3	6.5%	<1%
Financial Services						
	NIL	NIL	NIL			
Facilities and Estates						
	NIL	NIL	NIL			
Governance						
Patient Records / Identification	1	0	0	1	100%	<1%
IM & T						
Patient Records / Identification	5	12	9	26	78.7%	3%

	Reporting Period 2015/16 Q4					
	Jan	**Feb**	**March**	**Total Number of Reported Clinical Incidents**	**Top 3 as a % of Reported Divisional Total**	**Top 3 as a % of Reported Corporate Total**
IT Problems	1	2	1	4	12.1%	<1%
IT Problems			1	1	3%	<1%
Total Number of top three categories	**79**	**105**	**109**	**293**		

The table below shows the top ten cause groups of the patient safety incidents and the percentage of incidents with the same cause group across the Trust:

Cause Group	Incidents reported across the Trust with Cause Group	% of Incidents reported across the Trust with Cause Group
Admission / Discharge / Transfer	119	14.0%
Clinical Management	116	13.6%
Medication	111	13.0%
Patient Records / Identification	101	11.8%
Communication	92	10.8%
Equipment	36	4.2%
Haemorrhage	33	3.9%
Blood Transfusion	32	3.8%
Injury	32	3.8%
Appointment Error	30	3.5%

Emerging Themes

Using the same 'top 3' approach more detailed analysis of the incident categories has been undertaken to identify a number of emerging themes in relation to the category of incident and severity of patient harm resulting from these incidents.

The majority of incidents below have been graded as no or low harm. However, it must be noted that not all incidents that occurred in Q4 have been managed and graded by reviewers and therefore are not included in the analysis below.

1 Admission /Discharge and Transfer

	1 Near Miss	2 No Harm	3 Low Harm / Minor	4 Moderate Harm - Moderate	5 Severe Harm	6 Death Caused by a PSI	7 Death Not Caused by a PSI
Discharge - Planning Failure	2	49	4				
Admission - Planning Failure	1	16	1				
Capacity Issue	2	5	3				

Actions taken include:

- The discharge process is being reviewed across the first floor.
- Staff reminded to include relevant information in the community order and to identify if patient is under enhanced team
- Staff reminded via daily brief of NIPE process and to not discharge babies who are already Amber

2 Clinical Management

Cause 1	1 Near Miss	2 No Harm	3 Low Harm / Minor	4 Moderate Harm - Moderate	5 Severe Harm	6 Death Caused by a PSI	7 Death Not Caused by a PSI
Failure To Follow Clinical Guidelines		15	4	1			
Shoulder Dystocia		11	4				
Treatment / Procedure - Delay/Failure		9	2				

Actions taken include:

- VTE guidelines have been discussed in the ward huddles. All staff made aware that all patients with a VTE score of 2 and above require TED stockings as per guidelines, regardless of type of surgery unless contraindicated**.**
- Community Brief highlighting a trend recently in failing to request Growth scans for previous IUGR pregnancies.
- Meeting arranged to discuss scanning capacity and rotas at trust and satellite clinic

3 Medication

	1 Near Miss	2 No Harm	3 Low Harm / Minor	4 Moderate Harm - Moderate	5 Severe Harm	6 Death Caused by a PSI	7 Death Not Caused by a PSI
Medicines - Prescribing		28					
Medicines - Security	1	19					
Medicines - Policy/guidance		13					

Actions taken include:

- SBAR being amended to prompt staff to have medications prescribed when patients are admitted as inpatients.
- Staff informed via brief to ensure patient own medications are taken from women on admission and locked away in medicines cupboard
- Meeting arranged with chair of Medicines Management to review pharmacy order sets.

Serious Incidents and Never Events

There were 10 serious incidents submitted to StEIS as per NHS England StEIS reporting criteria during 2015/16 Q4. None of them being a Never event as defined in the NHS Never Event Framework.

The chart below provides a brief overview of the reported StEIS serious incidents and their current status

Service	StEIS No. & Ulysses No.	StEIS Reported Date	StEIS Report Due Date	StEIS Reporting Criteria & LWH Reference Summary	RCA and Action Plan to CCG
Hewitt Centre (RMU)	2016-299 Ulysses Ref: 39546	05/01/2016	31/03/2016	Surgical / Invasive procedure incident meeting SI criteria Removal of a left tubo-ovarian abscess including left tube and ovary following drainage of endometrial haematoma	Investigation report submitted to CCG on 30/03/2016
Gynaecology	2016-710 Ulysses Ref: 39593	08/01/2016	05/04/2016	Surgical / Invasive procedure incident meeting SI criteria Retention of uncounted 'Aquacell' pads post –surgery. CCG confirm not a Never Event.	Investigation report submitted to CCG on 05/04/2016
Gynaecology	2016-1835 Ulysses Ref: 39840	21/01/2016	09/05/2016 By granted extension	Unexpected / potentially avoidable injury requiring treatment to avoid death or serious harm. Failure to act on X-ray finding (2014)	Investigation in progress
Maternity	2016-2057 Ulysses Ref: 39831	22/01/2016	19/04/2016	Maternity / Obstetric incident meeting SI criteria : baby only (this include foetus, neonate and infant) IUD confirmed at review following admission for Induction and administering of Prostin	Investigation report submitted to CCG on 15/04/2016
Maternity	2016-3431 Ulysses Ref: 40042	05/02/2016	04/05/2016	Maternity / Obstetric incident meeting SI criteria : mother and baby (this include foetus, neonate and infant) Whiston Pt self-presented unwell. On examination IUD of twin 1 confirmed. Caesarean performed. Baby to LWH SCBU, Mother transferred to external Trust.	Investigation in progress (Whiston)
Neonatal Unit	2016-4830 Ulysses Ref: 40048	19/02/2016	18/05/2016	Unexpected / potentially avoidable injury requiring treatment to avoid death or serious harm. Investigation of known medication subsequent to baby's death. (Parents unhappy with cause of death).	Investigation in progress
Gynaecology (BPAS)	2016-5875 Ulysses Ref: 40484	24/02/2016	27/05/2016	Surgical/Invasive Procedure meeting SI criteria (BPAS)	Investigation in progress.

Service	StEIS No. & Ulysses No.	StEIS Reported Date	StEIS Report Due Date	StEIS Reporting Criteria & LWH Reference Summary	RCA and Action Plan to CCG
Gynaecology	2016-5869 Ulysses Ref: 40531	01/03/2016	27/05/2016	Unexpected / potentially avoidable injury requiring treatment to prevent death or serious harm	Investigation in progress
Gynaecology	2016-6498 Ulysses Ref: 40605	08/03/2016	06/06/2016	Surgical/Invasive Procedure meeting SI criteria (BPAS)	Investigation in progress
Neonatal Unit	2016-8374 Ulysses Ref: 40963	24/03/2016	22/06/2016	Maternity / Obstetric incident meeting SI criteria : baby only (this include foetus, neonate and infant) Neonatal death, following Emergency Caesarean and Transfusion.	Investigation in progress

Lessons learnt from serious incidents reported in Q3 2015/16

Service	StEIS No & Ulysses No.	StEIS Reporting Criteria & LWH Reference Summary	Root causal issues/ contributory issues identified	Lessons learnt
Maternity	2015-30450 Ulysses Ref: 37829	Medication incident meeting SI Criteria (Never Event 6: Insulin overdose)	• Lack of comprehensive fully multidisciplinary clinical management plan **Individual factors** • Lack of knowledge and experience caring for diabetic women and administering insulin via syringe **Organisational Factors** • Lack of post-natal care planning and instruction for staff • Inappropriate location of care delivery • Lack of dedicated Diabetes specialist nursing service for the post-natal ward. • Lack of embedded learning from Never Event involving insulin and IV syringe in 2014 resulting in an overdose of insulin. • Delay in training the midwives in Safe use of Insulin as part of mandatory training.	• Despite introduction of specific training on the Safe use of Insulin some staff remain unclear regarding administration • Staff inappropriately took advice from the patient as they believed her to be an “expert” in her own condition • Lack of learning from previous incident and NPSA alert.

Service	StEIS No & Ulysses No.	StEIS Reporting Criteria & LWH Reference Summary	Root causal issues/ contributory issues identified	Lessons learnt
			• No self-administration of medicines policy **Task Factors** • The "expert" patient was not observed drawing up or administering the insulin • Insulin was not prescribed for a bolus dose • Lack of instruction for the midwives in relation to medication prescription and administration via the peg. **Education / Training Factors** • Safer use of Insulin training put in place January 2015, though not all staff have been trained • General lack of knowledge in the ward midwives in relation to caring for a diabetic mother with such complex needs.	
Neonatal Unit	2015- 33065 Ulysses Ref: 37343	Maternity / Obstetric incident meeting SI criteria : baby only (this include foetus, neonate and infant)	**Root Cause** • Inadequate training of staff in optimal chest drain insertion technique resulting in insertion of guidewire and chest drain too far into the chest causing damage to a pulmonary artery branch. • **Contributory factors** Seldinger guide wire marking is suboptimal and easily obscured during insertion procedure. • Lack of clarity about whether the technique should be a two-person procedure.	• More robust training required in relation to insertion of chest drains. • Staff education around requirement for analgesia following insertion of a chest drain • Staff education around requirement for feeding tube even when baby NBM

Service	StEIS No & Ulysses No.	StEIS Reporting Criteria & LWH Reference Summary	Root causal issues/ contributory issues identified	Lessons learnt
Neonatal unit	2015-33370 Ulysses Ref: 38108	HCAI/ Infection control incident meeting SI criteria Unexpected Neonatal Death	**Root Causes** • The root cause of the incident was failure to recognise the clinical • deterioration at midnight between 30/9/15 and 1/10/15 which led to a 12 to 14 hour delay in administering antibiotics. **Contributory factors** • The major contributory factor was an inappropriate work load for number and • skill mix of the staff on duty.	• The need for education in the use of the HERO policy. • The need for an improved and structured handover system • The need to review the trigger list in relation to escalation of medical workload
Neonatal unit	2015-35141 Ulysses Ref: 38623	Diagnostic incident including delay meeting SI criteria (including failure to act on test results) Delayed diagnosis	**Root Cause** • Colonisation of Baby W with MRSA. **Contributory factors** • High prevalence of MRSA colonisation rates on the neonatal unit.	• The need to have regular signing off of radiology reports by the neonatal intensive care team • The need for improved documentation of all clinical reviews done on babies • To raise awareness of potential fractures if a sudden rise of serum alkaline phosphatase is noted
Maternity	2015-38471 Ulysses Ref: 39220	Maternity / Obstetric incident meeting SI criteria : baby only (this include foetus, neonate and infant)	**Contributory Factors** • Type 2 diabetes with sub optimal diabetic control in pregnancy **Root Causes** • Failure to recognize and act on significant fetal compromise • Failure to adequately control diabetes following steroids	• A specific programme is required to enhance staff knowledge regarding fetal monitoring • Women needing more than 4 hourly observations should not be transferred overnight to the ward
Hewitt Centre (RMU)	2016-299 Ulysses Ref: 39546	Surgical / Invasive procedure incident meeting SI criteria Removal of a left tubo-ovarian abscess including left tube and ovary following drainage of endometrial haematoma	**Root causes:** • With the information available at the time of the investigation the group agreed that the root cause of the incident was drainage of an endometrioma without appropriate antibiotic cover. • The root cause of the antibiotic not being administered was in this instance a failure to follow guidelines.	• There was a lack of a multi-disciplinary team discussion at the end of the patient's procedure. This was felt to be a missed opportunity for all healthcare professionals present to note that an endometrioma had been drained and the need for antibiotic cover. • For the medical staff directly involved in the incident the local induction process for the department, including the need to read all relevant

Service	StEIS No & Ulysses No.	StEIS Reporting Criteria & LWH Reference Summary	Root causal issues/ contributory issues identified	Lessons learnt
				SOPs, had not been implemented • It was agreed that Trust wide the local induction and competency assessment process for locum / sessional medical staff could be improved.

Performance by Service – Reported Incident Investigations and Closure

As stated earlier in this report regular automated reports for the Web Holding File continue to assist managers in monitoring the number of incidents waiting to be managed in Ulysses. The Governance Support Officers currently merge incidents on a daily basis, though with changes to contracted hours and leave commitments this has not always been achieved. The Governance Support Officers upload to NRLS on at least a weekly basis. A daily web holding file report on the number of incidents managed and waiting to be merged by the risk team has been developed to monitor the merging activity.

The table below details the position of the web holding file on the **20th April 2016,** and shows the status of the incidents by area for the months they were reported in (NB not the month that the incidents occurred).

	January			February			March			Total in WHF
	Managed awaiting Merge into live system	Under Review	Awaiting Managers Form	Managed awaiting Merge into live system	Under Review	Awaiting Managers Form	Managed awaiting Merge into live system	Under Review	Awaiting Managers Form	
Women and Children's Service										
Cheshire, Merseyside Neonatal	1	1		10	2		9	2		25
Financial Services					2	1				3
Genetics			3		1	1	2		8	15
Governance			1			3				4
Gynaecology And Surgical Servi		1	1		1	1	2	6	6	18
Hewitt Centre (RMU)					1	2			2	5
Maternity And Imaging			3		4	12		1	6	26
Neonatal And Pharmacy		1	1					6	1	9
Corporate Services										0
Patient Administration Service			1			1			5	7
Facilities & Estates			1		1	1			9	12
IM & T						1			1	2
Total	15			45			66			126

NRLS Upload - Assessment of Trust NRLS Reporting Status

The NRLS reporting data for the period 1st April 2015 to 30th September 2015 reported that 11564 incidents were submitted within the agreed timeframe to the NRLS by 30th November 2015.

The latest NRLS report identified the Trust as the second highest reporter of incidents benchmarked against 18 acute specialist organisations maintaining this position from the previous 6 month reporting period, as presented in the Qtr 2 'SEE' report.

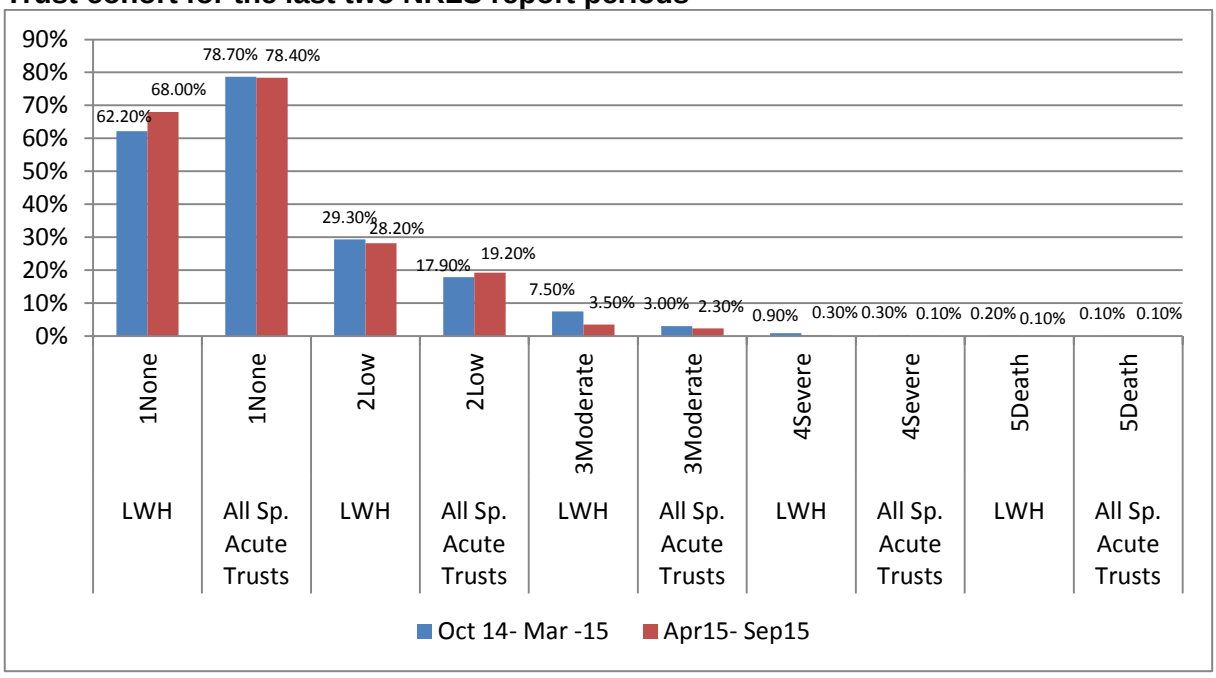
Table 1 &Figure 22 below outline the degree of harm and incident type categories that were reported within this period that have been managed and submitted to the NRLS.

Table 1: Degree of harm for the incidents uploaded to the NRLS:-

Reporting period	No Harm	Low	Moderate	Severe	Death
October 2014-March 2015	823	387	99	12	2
April 2015-September 2015	1063	441	55	4	1

In comparison with the acute specialist organisation cluster this Trust reported a higher proportion of low, moderate and severe harm incidents in previous quarters. This is again the case, as shown below. Though there is evidence in no harm events possibly indicating a raised level of reporting Near Miss incidents with the potential to learn prior to realisation of a recurrence resulting in harm. The trusts reported less incidents with moderate, severe harm or death as a consequence. Since these are likely to receive greater recognition this could support the interpretation that the Trust is reporting near misses and preventing more serious recurrences.

Figure 1 Reported Incident harm levels for this Trust and the Acute Specialist Trust cohort for the last two NRLS report periods



The appropriate grading of incidents to ensure that actual, not potential, harm is continues to be included in the Ulysses training delivered to staff.

Incidents categorised as deaths were all reported and investigated as Serious Incidents and have action plans associated with them.

Recommendations from this report:

Continue to deliver training for reviewers of incidents to include:

1. A reminder that patient details must be appropriately entered in the 'People involved in the incident' section of the report for incidents involving patients.
2. If an action is required it should be documented in the "add an action" section in Ulysses
3. Actions should address preventative measures not just record immediate actions
4. Grading of incident s must ensure that actual, not potential, harm is recorded.

Non-clinical Incidents *(Health and Safety Incidents)*

In the 4th Quarter of 2015/16; there were 73 non-clinical Health & Safety incidents, of which 24 were staff related incidents, 26 were organisational (non-clinical) related incidents and 23 related to patients, visitors or members of the public.

There is a significant decrease in baby tagging alarm trigger events incidents this quarter, with 23 incidents reported, a reduction of 24. Further analysis of this decrease will be outlined following the breakdown of incidents table below:

	SERVICE AREA						TOTAL
	MATERNITY INC. N ICU	GYNAECOLOGY	SPECIALIST SERVICES	ESTATES & FACILITIES INC. SECURITY	CORPORATE FUNCTION	IMAGING & PHARMACY	
STAFF INCIDENTS							
MOVING AND HANDLING	0	2	0	0	0	0	**2**
PHYSICAL ASSAULT	0	0	0	0	0	0	**0**
VERBAL ABUSE	4	2	0	1	0	0	**7**
PERSONAL INJURY / ILL HEALTH	3	4	0	0	1	0	**8**
NEEDLESTICK INJURIES	6	0	0	0	0	0	**6**
SLIPS, TRIPS & FALLS (non-clinical)	0	1	0	0	0	0	**1**
TOTAL STAFF	**13**	**9**	**0**	**1**	**1**	**0**	**24**
ORGANISATIONAL							
COSHH	0	0	0	0	0	0	**0**
COLLISION	0	0	0	0	0	0	**0**
ENVIRONMENTAL ISSUES	1	1	0	0	0	0	**2**
FIRE	0	0	0	0	0	0	**0**
INFRASTRUCTURE	0	0	0	0	0	0	**0**
PLANT & NON-MEDICAL DEVICE / EQUIPMENT	0	0	0	0	0	0	**0**
SECURITY	23	0	1	0	0	0	**24**
WORK-RELATED STRESS	0	0	0	0	0	0	**0**
TOTAL ORGANISATION	**24**	**1**	**1**	**0**	**0**	**0**	**26**
VISITORS / CONTRACTORS / MEMBERS OF THE PUBLIC INCIDENTS							
ILLICIT DRUGS	0	0	0	0	0	0	**0**
PERSONAL INJURY / ILL HEALTH	1	0	0	0	0	0	**1**
SLIPS, TRIPS & FALLS (non-clinical)	0	0	0	0	0	0	**0**
PHYSICAL ASSAULT	0	0	0	0	0	0	**0**
VERBAL ABUSE	0	0	0	0	0	0	**0**
SECURITY	0	0	0	3	0	0	**3**
TOTAL VISITORS ETC.	**1**	**0**	**0**	**3**	**0**	**0**	**4**
PATIENT INCIDENTS							
PERSONAL INJURY / ILL HEALTH	3	0	0	0	0	0	**3**
SLIPS, TRIPS & FALLS (non-clinical)	1	1	0	2	0	0	**4**
PHYSICAL ASSAULT	0	0	0	1	0	0	**1**
VERBAL ABUSE	4	1	0	0	0	0	**5**
SECURITY	2	4	0	0	0	0	**6**
TOTAL PATIENTS	10	6	0	3	0	**0**	**19**
OVERALL TOTAL	**48**	**16**	**1**	**7**	**1**	**0**	**73**

Staff Incidents
Of the 24 staff related incidents, the majority occurred in the Maternity service area, 13 in total. The Gynaecology Services reported 9 incidents. There was 1 incident reported for Estates and Facilities and Corporate Functions each and a nil return for Imaging.

There were a total of 8 reported staff injuries; however, there was no underlying trend or theme. All were appropriately managed and minor in nature.

There were 6 needlestick injuries; once again the main causes of these injuries were due to poor disposal or colleagues injuring colleagues. This will be discussed with relevant training teams.

Organisational Incidents (non-clinical)
There were 26 incidents relating to non-clinical Health & Safety categories, a significant decrease of 30 from the last reporting period; the fall is attributed to the decrease in baby tagging alarm incidents.

Further analysis has shown that the majority of these incidents involved Security (24) of which 23 were baby tagging alarm incidents.

Incidents involving Visitors / Contractors / Members of the Public
There were 20 incidents involving patients and visitors during this quarter. There were 3 incidents within Estates, 6 within gynaecology and 11 within maternity.

There were 6 Security related incidents including two thefts from patients. All protocols and procedures were followed and documented appropriately. There were 5 incidents of verbal abuse and one physical assault amongst patients and visitors; majority of which were visitor towards patient. All were dealt with appropriately by staff (including the Security Team) and Police intervention sought, as required.

RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations)

There has been one incident reported in this quarter. A staff member received an injury to her shoulder during a manual handling procedure. A full formal risk assessment was undertaken and followed up with a review and guidance upon the staff member's recent return to work. An error in the transfer procedure was noted and discussed.

Working days lost due to RIDDOR reported incidents totalled 34 in this quarter.

The Trust is required to submit RIDDOR reportable incidents to the HSE within prescribed timescales. Persistent late reporting exposes the Trust to potential prosecution for non-compliance with the regulations.

Safety Senate

The Safety Senate has taken on the management and oversight of Health and Safety issues.
The April meeting included Health & Safety matters and the main agenda items were:
1. To discuss and monitor progress of individual departmental risk assessments and recommendations
2. To discuss and monitor progress of H&S related Risk Register entries
3. To receive and support the Manual & Load Handling report and action plan

4. To receive an update on the H&S Training Schedule

As a result, two incidents arising from risks highlighted in the GOPD departmental risk assessment and HSSU risk assessment have been escalated

Security Management

NHS Protect conducted a Security Management Inspection on 16th March and 17th March 2016. The inspection considered work undertaken in all 14 of the Security Management Standards encapsulated under the generic area of Prevent and Deter.

Based on the evidence supplied prior to the inspection and during the inspection process, the trust was given a green rating for eight standards:
3.4 Management of access control and movement of people within buildings/grounds
3.5 Protection of assets from procurement to decommissioning or disposal
3.6 Corporate asset register for assets >£5,000
3.8 Policies and procedures for the security of medicines and controlled drugs
3.11 Risk-based approach to identifying and protecting critical assets and infrastructure
3.12 Ability to increase security recourses in the event of an increased security threat
3.13 Suitable lockdown arrangements
3.14 Processes for prevention of infant abduction that are regularly tested, monitored and reviewed

Amber rating for one standard:
3.7 Departmental asset registers and records for business critical assets <£5,000

Red rating for five standards:
3.1 Training for the prevention of violence and aggression (Conflict Resolution Training)
3.2 Risk to Lone workers including violence and aggression
3.3 Distribution of national and regional NHS Protect Alerts
3.9 Staff and patient access to safe & secure facilities for the storage of personal property
3.10 Recording of all security related incidents in a comprehensive and systematic manner

Two of these standards, 3.1(Conflict resolution training) and 3.2 (Lone workers), were weighted. This meant a red rating in either one would, and has resulted, in an overall red rating for the generic area of Prevent and Deter.

NHS Protect made recommendations from their findings and work has already begun to action these recommendations. Standards 3.3, 3.6 and 3.9 are now completed and work is in progress to actions the recommendations that all relate to protecting staff from violence and aggression. The action plan is embedded below:

Action Plan - NHS Protect -LM.docx

Emergency Preparedness Resilience & Response (EPRR)

The junior doctor industrial action (IA) on 6th & 7th April was planned as part of the ongoing dispute over the new contract for junior doctors. It resulted in the provision of

emergency care only during the period of 08:00 Wednesday 6th April to 08:00 Friday 8th April 2016.

Operational pressures were extended beyond this period as 11 junior doctors rotated into new posts and contingency plans had to be put in place to ensure that all doctors in training had received an induction prior to commencing clinical duties.

What went well?

- Multi-disciplinary planning meetings took place weekly to discuss and share plans.
- Training for junior doctors was changed to ensure all junior doctors had their induction training before commencing clinical duties
- To prevent cancelling patient appointments all non-essential elective surgery/procedures and clinic lists were closed weeks prior to the industrial action.

What didn't go so well?

- Clinic lists that were initially closed by Head of Operations were reopened and significantly overbooked. This resulted in clinics over running into the afternoon and no doctors were available for the wards.

Lessons Learned

- Heads of Operations needs to check clinic lists are not overbooked or re-opened prior to IA.

Further strikes are planned for 26th & 27th April 2016. However, junior doctors will not be providing emergency care during this episode of IA which means that a considerable amount of patient appointments and elective procedures have been cancelled to ensure the provision of safe services for women and their families during this period.

CAS Alerts

100% of the 20 CAS Alerts received in this quarter were responded to within their deadline targets. No alerts breached the expected deadline dates during this period and none were carried forward from previous periods.

The H&S Manager issued action cards to all CAS Leads and Deputies in December, 2015. This also served as a revalidation exercise of named leads and deputies in order to keep the CAS distribution list up to date and ensure good communication. A training need has been identified in light of this exercise and sessions are currently being arranged for use of the Ulysses Alerts System.

Sign up to Safety

In December 2014, the Trust engaged in a three year 'Sign up to Safety' campaign with aims to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group. The ambition is to halve avoidable harm in the NHS over the next three years and save 6,000 lives as a result.

The Trust declared four pledges to support the patient safety improvement campaign in order to reduce avoidable harm by 50%. The Trust received confirmation in March 2015 that it had been successful in two of the four 'Sign up to Safety' bids for NHS LA funding. The successful bids were "Reducing the incidence of babies born with Grade 2/3 Hypoxic Ischaemic Encephalopathy" and "Reducing the incidence of sepsis".

The Trust has given written commitment to the NHS LA that allocated funds will only be used in relation to this project and has published a summary of its bid on its website at:-
(http://www.liverpoolwomens.nhs.uk/About_Us/Sign_up_to_Safety.aspx)
Details are available of the anticipated outcomes and a progress report is available detailing where the Trust is up to in terms of implementation. The Trust is committed to sharing feedback from the project, along with safety and learning themes, with our external partners and directly with the Safety and Learning team at the NHS LA

Claims and Litigation

1. Claims and Litigation : Quarter 4 2015/16

LWH currently has 173 open claims lodged with the NHS Litigation Authority.

20 new clinical negligence claims were received (chart 1 refers);
5 Clinical Negligence claims closed with NIL damages;
7 Clinical Negligence claims settled (Table 1 refers). Damages amounted to £822,019

2. Employer Liability Claims – Chart 3 refers

1 new EL claims were received;
4 EL claims closed with NIL Damages;
No EL Claims settled

3. Public Liability Claims – Chart 3 refers

2 new PL claim was received;
1 PL claim closed – NIL damages;
No PL claims settled.

4. Coroners Directions

5 death notificatio
No Inquests were held.

5. Themes of new claims:

Chart 1 identifies the breakdown of new claims per clinical Division

Chart 1

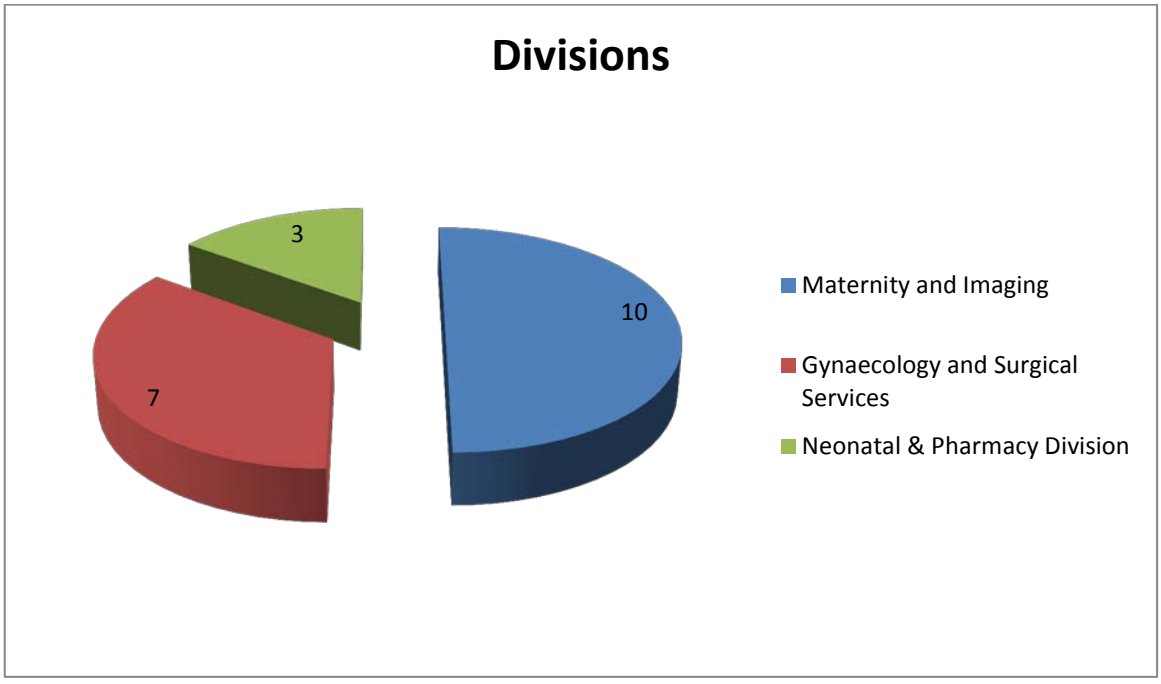


Chart 2 identifies themes within the new claims received.

Chart 2

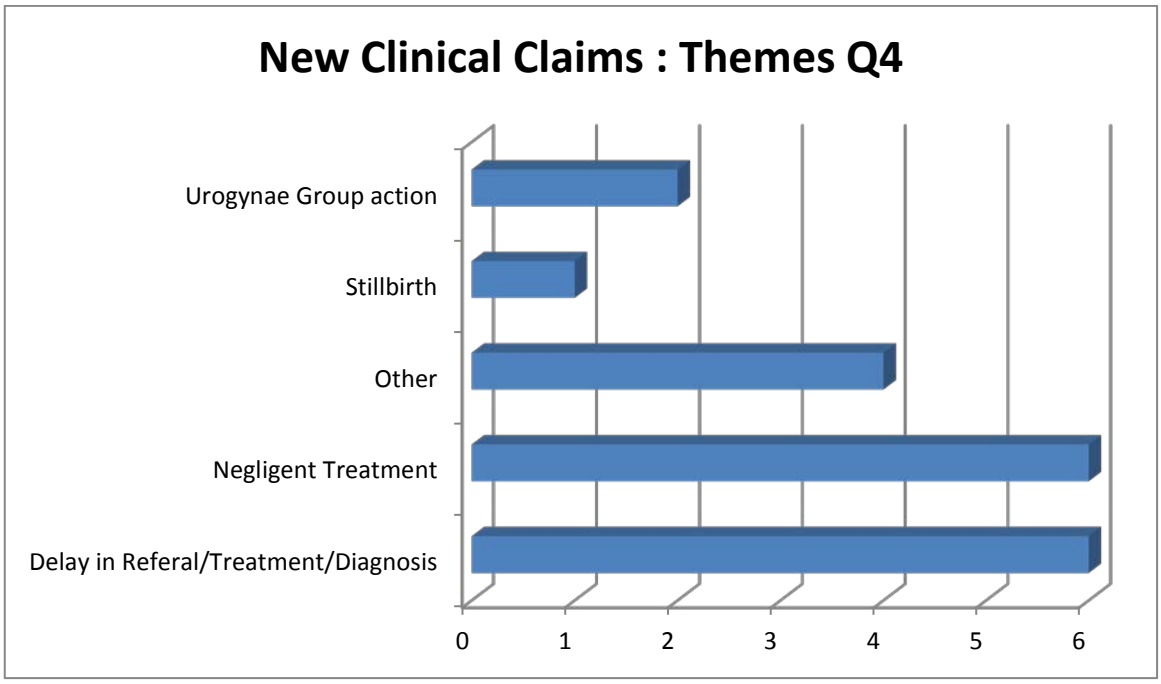
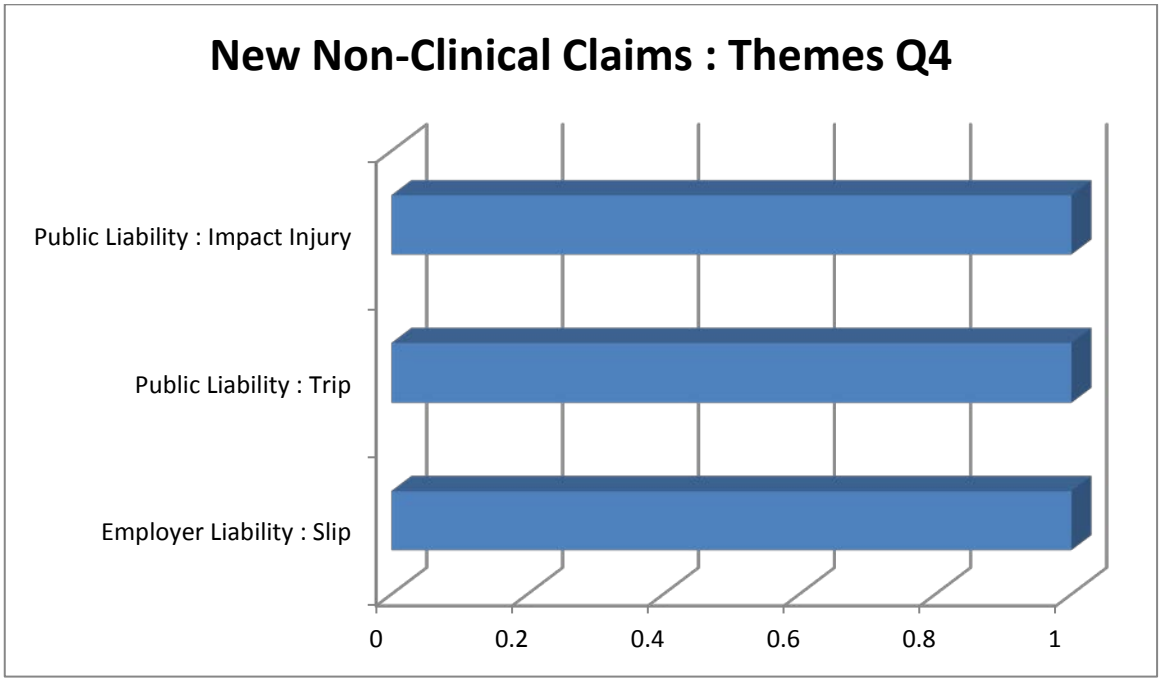


Chart 3

Chart 3 identifies themes within the new non-clinical claims



6. Settled Claims

Table 1 provides details as to whether settled claims had previously been investigated as an incident; complaint or PALS contact.

Table 1 – Settled Claims

Ref	Incident Date of Settled Claims	TYPE	Damages	Incident Review	Comp review
MCT320/216	24/05/2012	Group Action	£10.000	N	N
MCT320/218	12/10/1998	Group Action	£60,000	N	N
M10CT320/216	06/07/2000	Group Action	£10,000	N	N
13/62/1621	07/10/2012	Drug error/TOP	£12,000	Y	N
07/30/656	31/04/2004	Stillbirth	£108,000	N	Y
95/70/78	01/01/1994	Erb's Palsy	£280,000	Unrelated	N
10/07/859	16/02/2008	Ruptured uterus	£352,019	Y	Y

It can be seen that for 71% of the above settled claims there is no evidence available of an investigation relevant to the nature of the claim. The Trust was not recording its incident investigations electronically prior to 2006 which is likely to account for this figure. 86% of the above settled claims had not been the subject of a previous complaint.

7. Lessons Learned from Settled Claims included:

i. 1 – 3 Group Action

Lessons learned and changes implemented in respect of Group Action claims have previously been reported;

ii. 4. Drug Error (Misoprosta)l 13/62/1621

- The Management of Miscarriage Guideline/Pathway was amended to include a discussion with the patient of the 3 available treatment options must be documented in the medical records;
- The internal process for the dissemination of important changes in clinical management was reviewed;
- Medical Staff were advised not to use the term "inevitable miscarriage";

iii. 5. Stillbirth - 07/30/656

- **P**atients not in established labour with no obvious cause of pain but requiring opiate analgesia should be reviewed by a doctor and a plan of care developed and implemented;
- Review process for prioritisation and allocation of patients prior to staff handover;
- Explore development of risk assessment process to facilitate prioritisation of patients and provide visual up-date of dependency of women in antenatal and postnatal ward areas;
- Ensure patients are informed in cases where a medical review is required that they must remain on the ward until the review has taken place;
- Supervisor of Midwives referral regarding midwives' documentation.

iv. 6. Erb's Palsy 95/70/78

- This was a 1995 delivery. Due to the passing of time, many changes have occurred in particular, specific training for obstetric emergencies is now mandatory on a 3 yearly basis for doctors and annually for midwives.

v. 7. Ruptured Uterus 10/07/859

- It was accepted that, in cases of early pregnancy, the Gynaecology Division's guideline regarding the use of Misoprostol was inappropriate. The guideline was revised as a result of this claim and closer monitoring of such patients was introduced.

8. Neonatal and Pharmacy

No Neonatal or Pharmacy Divisional Claims settled or closed during Quarter3.

9. Non-Clinical Claims : Employer and Public Liability

No Non-Clinical claims closed or settled in Quarter 4

10. Prevention of Future Deaths/Coroners Concerns

No PDF requests were received during Quarter 4.

Safeguarding Children

Safeguarding Supervision

NSPCC have provided training to 10 LWFT staff. This ensures the organisation has the ability to provide appropriate safeguarding supervision to all staff who hold a safeguarding children caseload as well as group supervision to any staff who work in high risk areas e.g. Emergency Room and the Bedford Centre.

LWFT now have 12 Safeguarding Supervisors and a meeting has been convened by the Named Nurse for Safeguarding Children to discuss the delivery of Safeguarding Supervision across the Trust. This will begin in April 2016.

External Partnership Working

Following a directive from the external Adult Safeguarding Board, a decision has been made to pilot LWFTs suggestion of having one 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 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 is currently in discussion with Merseyside Police and the Local Authority to address this. This work will continue in to 2016/17.

The Local Authorities have now agreed with LWFTs suggestion to have one Single Agency referral to all Local Authorities when there is a concern regarding a child. This is currently in progress. This would affect Trust staff greatly, as such a full communication drive will be required to ensure all LWFT staff are aware and supported.

Serious Case Reviews (SCR)

Child 1

Child 1 was delivered here at LWFT. Mother is now known to have learning difficulties, which had not been identified prior to delivery. Child 1 suffered multiple unexplained fractures.

Final report due: 19/05/2016

Child 2

Child 2 suffered from unexplained multiple fractures and bruising. Child 2, whose mother was originally from outside the EU area, was delivered in LWFT with is presently in Foster Care. Mother had another child that did not reside in the UK. The investigation is focused on the use of interpreters following previous domestic abuse disclosures.

This case shares the same timeline as Child 1.

Child R (was GC)

This is a Knowsley case of a baby who was delivered at Ormskirk Hospital. The baby was admitted to LWFT Neonatal Intensive Care Unit (NICU) post-delivery. Following discharge and at 6 months old, baby was found to have unexplained injuries.

The report will not be available until September.

Safeguarding Training
Safeguarding Training levels are as follows:

Specialty & Level	Staff trained	Staff Required	Compliance
Safeguarding Level 1+2 (Adults and Children)	**1183**	**1358**	**87%**
Safeguarding Children Level 3	**615**	**675**	**91%**
Safeguarding Children Level 4	**2**	**2**	**100%**
Safeguarding Adults Level 3	**452**	**566**	**80%**

Safeguarding Adults

Dementia and Learning Disabilities
A business case for the Specialist Learning Disability Liaison Nurse post in all Acute Trusts submitted by the CCG has been further delayed. The Learning Disabilities Subgroup have challenged the delay and are currently awaiting a response. LWFT currently fund this post as part of the Safeguarding Team.

LCCG have approached all Trusts to sign up for the LD CQUIN and as part of that implement the elements of CIPOLD applicable to Acute Trusts. LWFT are already compliant with all of the CIPOLD recommendations.

MENCAP are asking for volunteer organisations to take part in a pilot to produce a standardised national training package for LD. LWFT have expressed an interest in participating in this project and will update further when specific details are available.

Harmful Practices

Preparatory work has been carried out by the Office of the Police and Crime Commissioner and Police, in consultation with statutory partners and voluntary sector in relation to rationalising the wider Protecting Vulnerable People agenda. A structure has been agreed in order to efficiently and effectively meet the demands of this priority.

In summary, 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 (MCJB) 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, (this will be a Sub-Group of PVP and LWFTs head of Safeguarding will sit on this) will feed into the new PVP Agenda and lead on Policy and Practice change Pan- Merseyside. This group will lead the work on the FGM Agenda for LWFT.

Safeguarding Risks
There is currently one safeguarding risk which is recorded on the Trusts Board Assessment Framework (1732). This has now been reviewed and agreed for the score to be reduced to 15 and is monitored by the Hospital Safeguarding Board.

All risks pertaining to safeguarding that are currently open on the Trusts Corporate Risk Register were reviewed and the remaining outstanding actions have been amalgamated and a new risk has been developed (1895). This is currently being managed and monitored within the service.

Safeguarding Referral Process
There is currently one safeguarding risk which is recorded on the Trusts Board Assessment Framework (BAF), item 1732. This is currently scored as 15 and is to be reviewed at GACA in Quarter 1 2016/17.

Safeguarding Service risk item 1895 continues to be monitored and by HSB. Two actions have been completed relating to Safeguarding Supervision and Auditing. This will continue to be managed and monitored through 2016/17.

Safeguarding Adult Reviews / Domestic Homicide Reviews
Currently there is no ongoing Safeguarding Adult Reviews, and no new Domestic Homicide Reviews (DHR's) reported. Safeguarding are currently awaiting response to 2 previous DHR IMRs submitted in Quarter 2.

EFFECTIVE

NICE Guidance

NICE guidance is monitored by the Effectiveness Senate. The Effectiveness Senate assess all released guidance and identify any that is relevant to this Trust. This is then allocated to a lead, who is expected to make an assessment of the Trust position and compliance against the guidance. During this quarter the following guidance has been applicable to this Trust:

December 2016:
Twenty Seven pieces of NICE guidance was released of which Four were applicable to the Trust.

January 2016:
Twenty Two pieces of NICE guidance was released of which Four were applicable to the Trust

February 2016:
Thirty Two pieces of NICE guidance was released of which Eight were applicable to the Trust

Guideline ID & Title	Guidance Lead	Month Issued	Month Allocated	Assessment Due	Breached
QS105 Intrapartum care	Jenny Butters	Dec 15	Jan 16	April 16	Yes
NG27 Transition between inpatient hospital settings and community or care home settings for adults with social care needs	Ruth Stubbs	Dec 15	Jan 16	April 16	No
NG29 Intravenous fluid therapy in children and young people in hospital	Balamurugan Palanisami	Dec 15	Jan 16	April 16	No
NG31Care of dying adults in the last days of life	Lesley Allsopp	Dec 15	Jan 16	April 16	No
QS109 Diabetes in pregnancy	Umber Agawal	Jan 16	Feb 16	May 16	No
QS111 Obesity in adults: prevention and lifestyle weight management programmes	Linda Martin	Jan 16	Feb 16	May 16	No
QS112 Gastro-oesophageal reflux in children and young people	Balamurugan Palanisami	Jan 16	Feb 16	May 16	No
NG33 Tuberculosis	Sam Parry/Nicky Murdoch	Jan 16	Feb 16	May 16	No
QS113 Healthcare-associated infections	Tim Neal	Feb 16	Mar 16	June 16	No
QS114 Irritable bowel syndrome in adults	Ruth Stubbs	Feb 16	Mar 16	June 16	No
QS115 Antenatal and postnatal mental health	Noreen Clarke	Feb 16	Mar 16	June 16	No
QS116 Domestic violence and abuse	Mandy McDonough	Feb 16	Mar 16	June 16	No
UpdateCG185 Bipolar disorder: assessment and management	Helen Scholefield	Feb 16	Mar 16	June 16	No
NG43 Transition from children's to adults' services for young people	Lynn Greenhalgh	Feb 16	Mar 16	June 16	No

Guideline ID & Title	Guidance Lead	Month Issued	Month Allocated	Assessment Due	Breached
using health or social care services					
DG21 Integrated sensor-augmented pump therapy systems for managing blood glucose levels in type 1 diabetes (the MiniMed Paradigm Veo system and the Vibe and G4 PLATINUM CGM system)	Helen McMamara	Feb 16	Mar 16	June 16	No

Clinical Audit

A report detailing progress is produced by each specialty within the Trust on a quarterly basis. This is considered at the Clinical Audit Committee and at local quality meetings. The dashboard below provides an overview of progress as of the end of this quarter:

Lead Specialty	Red 1	Red 2	Amber	Green 1	Green 2	Abandoned / Withdrawn	Total Audits
Neonatology	0	4	0	6	2	3	15
Neonatal Transport Network	0	1	0	0	1	0	2
Maternity	0	1	4	8	7	5	25
Gynaecology	1	3	6	6	3	0	19
Theatres & Anaesthesia	1	3	2	3	3	1	13
Hewitt Centre	0	1	1	1	0	1	4
Genetics	0	1	1	2	1	2	7
Imaging	0	0	1	1	0	0	2
Safeguarding	0	0	5	2	0	0	7
Governance	0	0	2	4	7	3	16
TOTAL	**2**	**14**	**22**	**33**	**24**	**15**	110

Key	
Audit not yet Registered	Red 1
Audit In Progress	Amber
Audit Report and Action Plan Received	Green 1
Evidence of Implementation Received	Green 2
Audit is past intended completion date	Red 2

At the beginning of each year each audit is assigned a priority level. This is based on where it fits in with wider Trust priorities, known risks, complaints and a range of similar metrics. The following table shows audits broken down by priority level, in a similar way to the reports prepared by the Trust's internal auditors do.

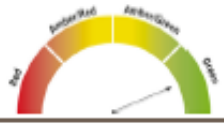
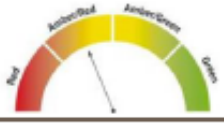
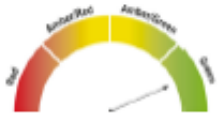
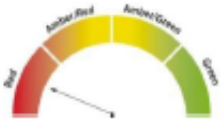
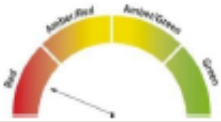
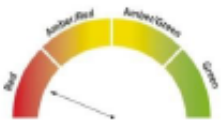
	Red 1	Red 2	Amber	Green 1	Green 2	Abandoned / Withdrawn		Total Audits
Very High (1)	1	3	7	8	6	4		29
High (2)	1	5	9	15	12	6		48
Medium (3)	0	5	6	5	5	5		26
Low (4)	0	1	0	5	1	0		7
Not Yet Classified	0	0	0	0	0	0		0
TOTAL	**2**	**14**	**22**	**33**	**24**	**15**		**110**

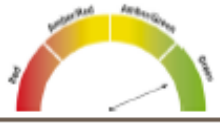
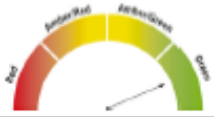
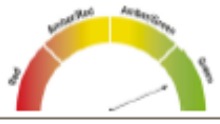
Each of the specialties are scheduled to produce their own detailed bi-annual report looking at all of their audits. These reports are presented at the Clinical Audit Committee and are then disseminated within the relevant specialty. The reports include details on the progress of all audits, their assurance level, any recommendations and update on progress towards making changes in practice.

The reports also discuss any additional audits that may be required for reasons such as newly released guidance or a trend in incidents. Any audits that are abandoned are discussed and the reasons for abandonment evidenced in full.

Internal Audit

The following is a summary of the 2015-16 internal audit work:-

Assignment	Executive lead(s)	Assurance level	Actions agreed		
			H	M	L
Emergency Planning / Business Continuity – Estates and Facilities Department (1.15/16)	Vanessa Harris, Director of Finance		0	0	1
World Health Organisation (WHO) Surgical Safety Checklist – Trust Audit Process (2.15/16)	Joanne Topping, Interim Medical Director	Design:  Application: 	1	2	5
Pharmacy Stock and Ward Materials Management (3.15/16)	Dianne Brown, Director of Nursing and Midwifery Allison Edis, Deputy Director of Nursing and Midwifery	Controlled Drugs:  Pharmacy Stock, Ward Stock and Stock held by Community Midwives: 	3	4	0
Pathology and Radiology Results (4.15/16)	Joanne Topping, Interim Medical Director Jeff Johnston, Associate Director of Operations		1	4	0
Risk Management (5.15/16)	Dianne Brown, Director of Nursing and Midwifery Allison Edis, Deputy Director of Nursing and Midwifery		0	3	5
Discharge Management - Monitoring & Reporting (6.15/16)	Dianne Brown, Director of Nursing and Midwifery Allison Edis, Deputy Director of Nursing and Midwifery Jeff Johnston, Associate		1	2	2

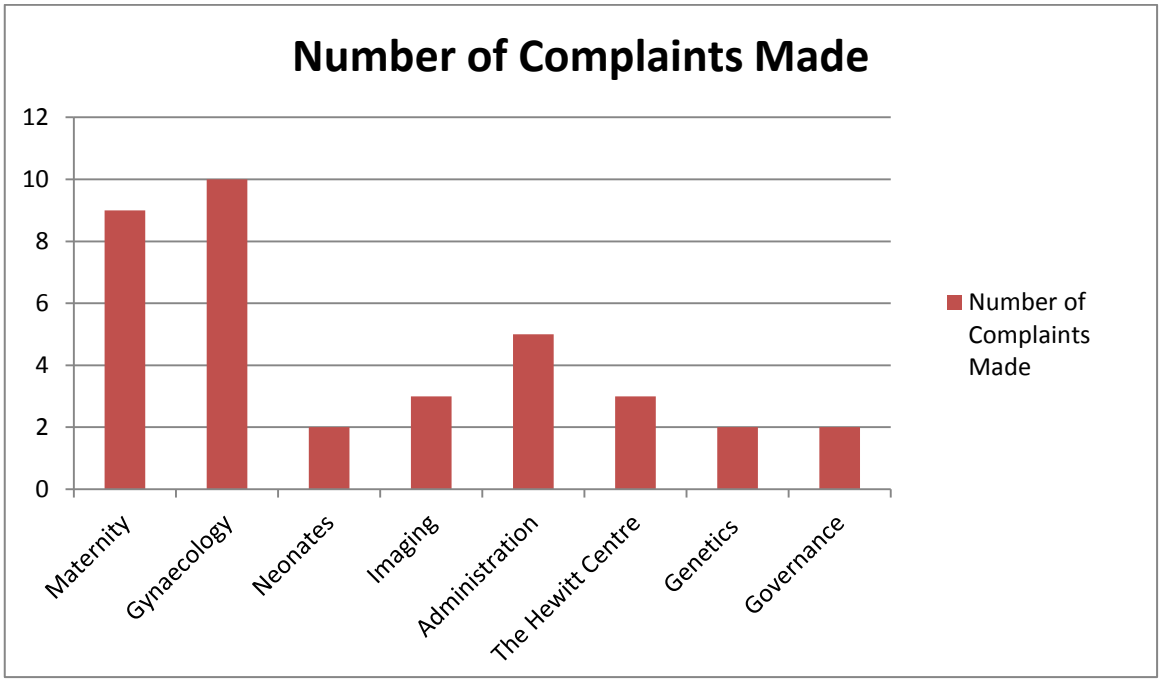
	Director of Operations				
Data Quality - Safer Staffing (7.15/16)	Dianne Brown, Director of Nursing and Midwifery Allison Edis, Deputy Director of Nursing and Midwifery		1	2	1
General Ledger & Financial Reporting (8.15/16)	Vanessa Harris, Director of Finance Jenny Hannon, Deputy Director of Finance		0	0	1
Income and Debtors (including Commissioning Activity) (9.15/16)	Vanessa Harris, Director of Finance Jenny Hannon, Deputy Director of Finance		0	0	0
Budget Monitoring and Cost Improvement Programme Delivery (10.15/16)	Vanessa Harris, Director of Finance Jenny Hannon, Deputy Director of Finance	Budget Monitoring:  CIP Delivery: 	0	0	3
Payroll (11.15/16)	Michelle Turner, Director of Workforce and Marketing		0	1	1
Information Governance Toolkit (Version 13) Review (12.15/16)	David Walliker, Chief Information Officer	Three Standards Agreed: One Overstated, One Unsubstantiated	1	2	1
Complaints, Concerns and Compliments (13.15/16)	Dianne Brown, Director of Nursing and Midwifery Allison Edis, Deputy Director of Nursing and Midwifery		0	1	8
Safeguarding – Review of the Trust's Audit Process and Safeguarding Inspection Questionnaire Spot Checks (14.15/16)	Dianne Brown, Director of Nursing and Midwifery Allison Edis, Deputy Director of Nursing and Midwifery		0	1	2
Follow Up of 'Red' Opinion Reports (15.15/16)	Dianne Brown, Director of Nursing and Midwifery Allison Edis, Deputy	Two Reasonable Progress (Pharmacy and Pathology) and one Good Progress	1	5	1

EXPERIENCE

Complaints

In Quarter 4 the Trust received 36 complaints, which is a slight increase of 2 received in the corresponding quarter in 2014/2015. However the Trust received a total number of 148 complaints in 2015/16 which is a significant decrease of 37 (20%) from the total number of complaints received in the previous year.

It is pleasing to see that there has been a significant decrease in the number of complaints received concerning Maternity reducing from 17 in Q3 to 9 in this quarter. Complaints concerning gynaecology remain the same in this Quarter as those received in Quarter 3. As is normal there is a slight fluctuation in the figures for each department between quarters.



Breakdown by Service Quarter 4

Complaints Resolved
In the final quarter 93.5% of complaints were completed within the agreed timescales. Two complaints breached the timescales; one complaint in maternity and one in gynaecology. An action plan to address this issue was submitted to the Board. Each week a report is submitted to SMT and Execs to escalate any complaints that are approaching the timescale which are causing concern. The target of 100% for action plans completed with each complaint was achieved.

Complaints which were upheld/not upheld/partially upheld
Of the 36 complaints which were received in this quarter which have been completed 5 were upheld, 4 were partially upheld and 7 were not upheld.

Duty Of Candour
The Duty of Candour was applied appropriately to the complaints that we received.

Complaint Themes
A significant number of complaints have as their main theme Treatment and Care (61%) poor communication (15&) and diagnosis problems (15%).

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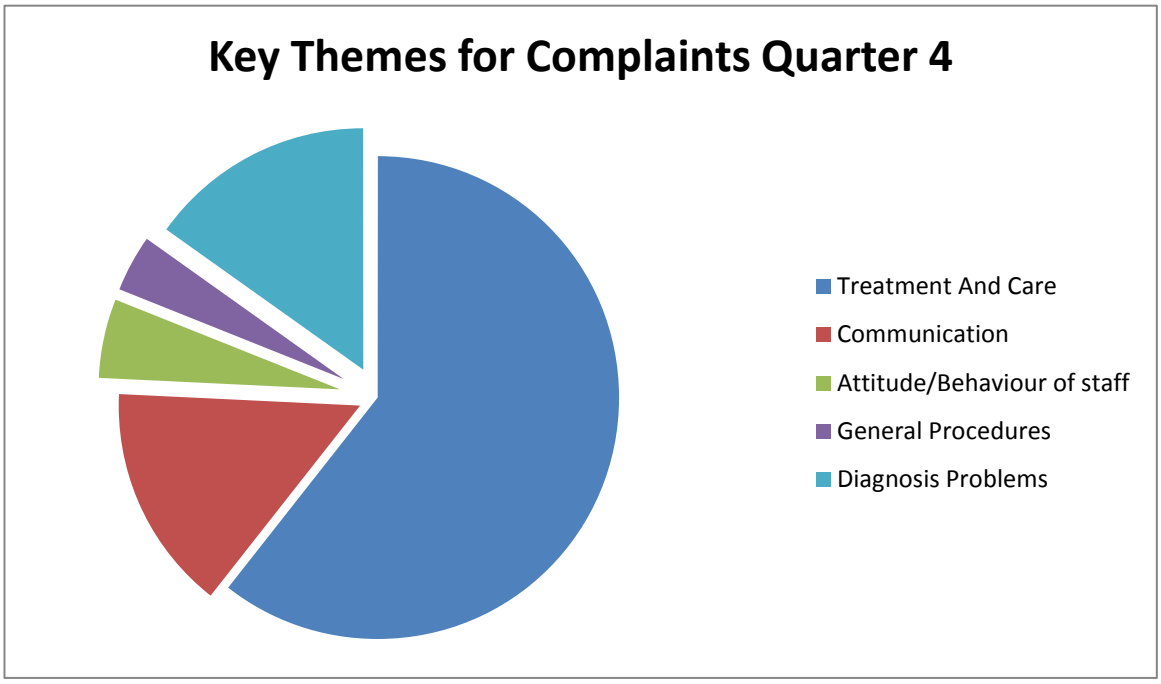
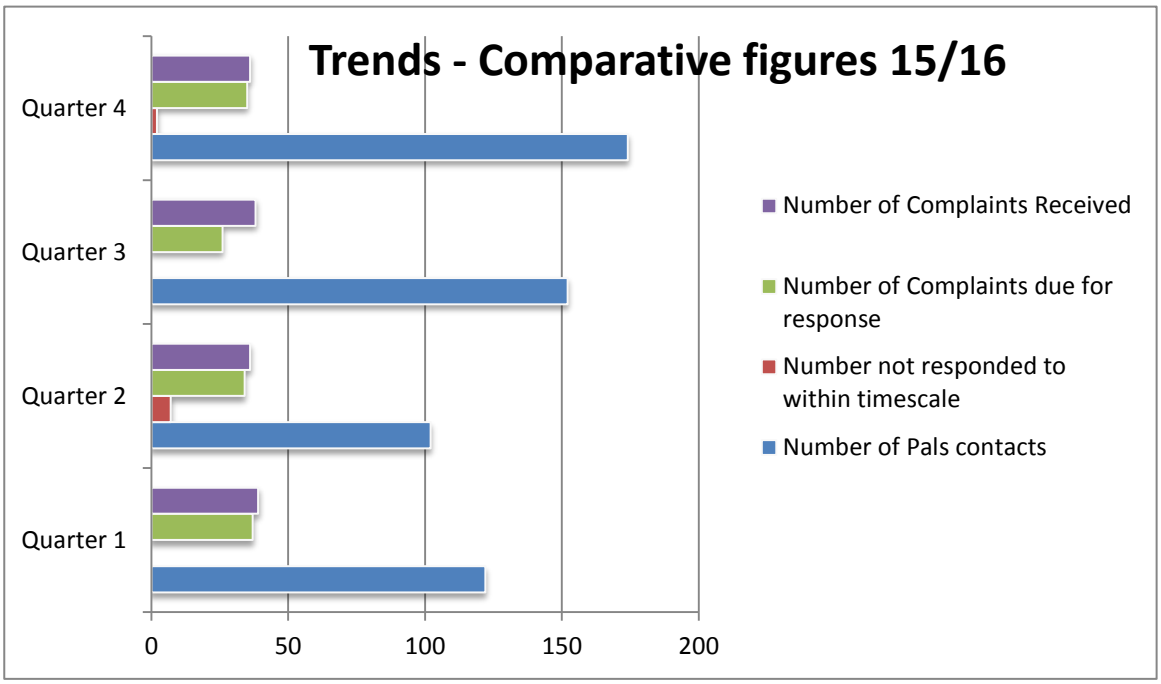


Breakdown of Themes from Complaints – Quarter 4

Each month the Experience Senate receives a report detailing the top three themes from Complaints and PALS concerns. The Chair report from the Experience Senate is received at Governance and Clinical Assurance Committee (GACA)

The Experience Senate makes recommendations to address any particular themes or trends that recur. In February 2016 the Senate discussed the recurring theme of poor staff attitude. A further meeting was held with Learning and Development colleagues to explore the options. Subsequently the Trust Community Care course is being promoted and a guide is being developed to support managers.

Trends



Comparative Figures for Year 2015/2016

The Chart indicates that the number of complaints received has remained steady throughout the year on a quarterly basis. However, this amounts to a total number of 148 complaints received in 2015/16 compared to the figure of 185 complaints received during 2014/2015, a 26% decrease. This gives an indication that lessons have been learnt during the year, reducing the number of complaints and highlights the success of the proactive approach of the Patient Experience Team to address issues and concerns locally through PALS.

Once again the number of PALS concerns over the last quarter has however increased significantly (152 in quarter 3 to 174 in Q4) Appointments, Staff Attitude and Communications continue to be the main themes, as previously highlighted.

The increase in PALS is partly due to the more proactive management of concerns by the Patient Experience Team, to prevent the escalation of concerns into complaints. This continued trend requires the support of Department managers to respond quickly and concerns forwarded.

Clinical Commissioning Group

The Trust did not receive any complaints this Quarter from the Clinical Commissioning Group

Parliamentary Health Service Ombudsman (PHSO)

The Trust received one request for documentation from the PHSO who have advised they are investigating a complaint that has been escalated to their office.

Patient Advice And Liaison Service (PALs)

During the final quarter of the year the PET has logged and managed 174 concerns through PALS, an increase of 12% on the previous quarter. This does not include the majority of concerns that are dealt with by managers and teams within departments being dealt with at source & unrecorded

Appointments, Staff attitude and general communication issues continue to remain the key themes.

Compliments
From April 2016 there will be full reporting on the number of compliments that the Trust receives which are collected from several sources. Previously compliments have not been collated in one area and the Patient Experience Team will now oversee the triangulation of compliments to feed into one report. The compliments are shared with the relevant teams at the Trust.

Audit
In January an audit was undertaken on Complaints, Concerns and Compliments. The subsequent report was favourable with very few recommendations to implement

Friends & Family

	Eligible	Responded	Satisfied
Inpatient	3176	376	371
			98%
A & E	2990	663	659
			99%
Mat – Antenatal	2087	19	19
			100%
Mat – Birth	2087	11	10
			91%
Mat – Postnatal	1819	33	31
			94%
Mat - Community	2111	30	29
			97%

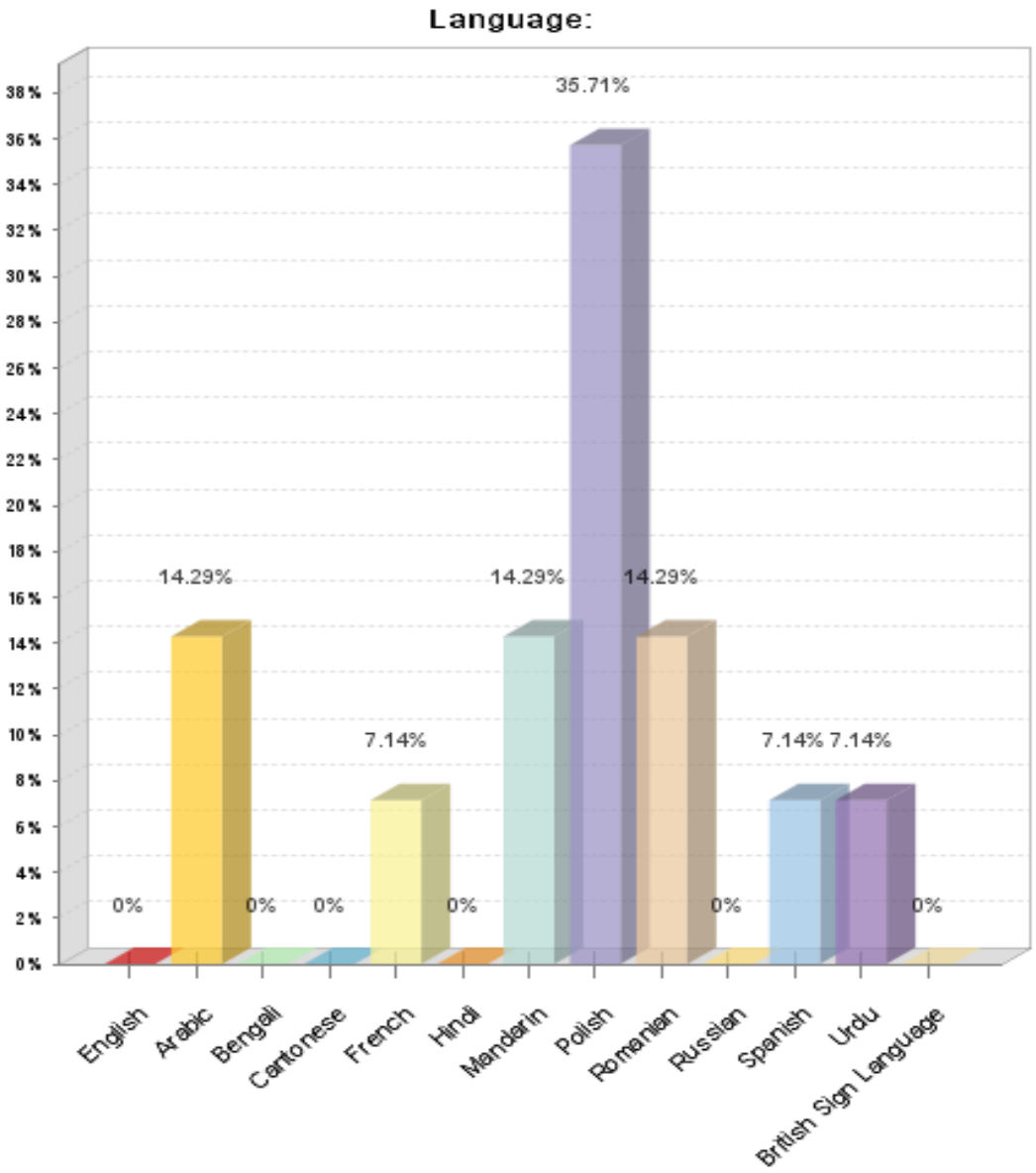
NHS England Successful Bid – Liverpool Women's awarded £10k

Following our successful bid for funding to purchase multi lingual kiosks to collect Friends and Family Test information from non-English speaking women, the project is now nearing completion. The kiosks have been installed and are available with 11 in-built languages as well as Easy Read and British Sign Language which now enables the Trust to engage fully with the increasing group of Non English speaking women using maternity services.

The kiosk offers the ability to monitor the feedback given in the antenatal department and Mat Base and we are using this information to improve their experience within each individual department.

The graph below shows the number of women that have used the kiosk to provide Friends & Family feedback by language.

We have also had considerable feedback via the kiosks from English speaking women which boosts the Friends & Family numbers from a previously low uptake area.



In response to the feedback from our non-English speaking women we have designed posters to display in key areas which are translated into the main languages.
As part of the engagement we have used the feedback we have received from non-English speaking women to design a number of posters that display different information regarding issues and concerns that was raised via feedback. The posters are in the main languages used.

Conclusion and Work for 2016/17

- In 2016 work will continue to successfully embed the new complaints policy.
- It is intended to develop a modern PALS service which will be visible in wards and in our waiting areas and public areas to gather feedback and address any issues locally as they arise. Research is underway to incorporate social media platforms into the PALS service we offer.
- Patient Opinion will be promoted utilising the support from Liverpool CCG who is providing a two year free license.

- The Patient Experience Team will support real time feedback by supporting local surveys. For example, gathering feedback from patients on mealtimes and food quality and also on preferences for visiting times
- The Experience Senate will continue to address current topics, including promoting disability access, monitoring all of our patient information, identifying issues through trends in PALS and Complaints.
- Promoting patient involvement on formal committees of the Trust
- We will continue to monitor the feedback via the interactive kiosks and work towards improving the non-English speaking patients experience within the hospital.

Glossary of Terms and Acronyms

CAS - Central Alerting System

CQC – Care Quality Commission

CTG – Cardiotocograph

DoLs – Deprivation of Liberty

EPRR - Emergency Preparedness, Resilience and Response

ESR - Electronic Staff Record

GFR - Glomerular Filtration Rate

HSCIC - Health & Social Care Information Centre

HSMR – Hospital Standardised Mortality Ratio

IOSH - The Institution of Occupational Safety and Health

LLETZ - large loop excision of the transformation zone

MCA - Mental Capacity Act

MEWS - Modified Early Warning Score

NHSLA – National Health Service Litigation Authority

NICE - National Institute for Health and Care Excellence

NRLS - National Reporting and Learning System

PALS – Patient Advice & Liaison Service

PFD – Prevent Future Deaths

PWC – Price Waterhouse Cooper

RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

StEIS - Strategic Executive Information System

SUS - Secondary Uses Service

SUI - Serious Untoward Incident

SEE – Safety, Effectiveness & Experience

Agenda Item No:	16/217
Meeting:	Trust Board
Date:	02/09/2016
Title:	Performance Dashboard - Month 4 - July 2016
Report to be considered in Public or Private?	Public
Where else has this report been considered and when?	Performance Group, Trust Management Group, Finance, Operations Board, Finance, Performance and Business Development Board
Reference/s	Quality Strategy, Quality Schedule, CQUINS, Corporate Performance Indicators, Monitor Assurance Framework
Resource impact:	

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

Which Board Assurance Framework risk(s) does this report relate to?	1. Deliver safe services 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?	Good Governance Staffing Safety Complaints
What action is required at this meeting?	To Note
Presented by:	Jeff Johnson
Prepared by:	David Walliker

This report covers (tick all that apply):

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

Other:

Monitor Compliance	✓		Equality and diversity	
NHS Constitution			Integrated business plan	

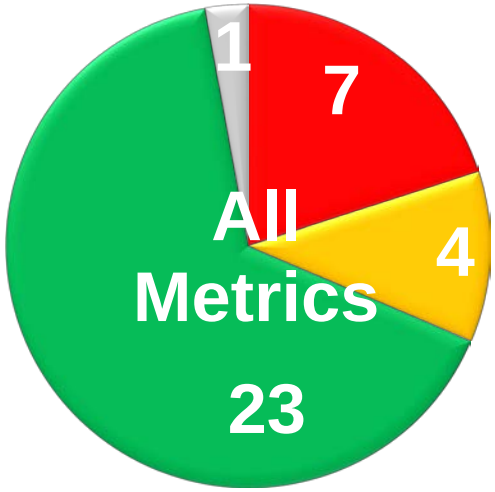
Publication of this report (tick one):

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

1. **Introduction and summary**
2. **Issues for consideration**
3. **Conclusion**
4. **Recommendation/s**

Liverpool Women's NHS Foundation Trust

Performance Report - Trust Board — Month 4 - July 2016



Performance Summary - Trust Board - Month 4 - July 2016

Overview

Of the 40 KPI's reported in the Trust Board Dashboard for July 2016, **23** are rated Green, **7** are rated Red and **4** are rated as Amber. The figure for Choose and Book are not yet available nationally.

The KPI's rated as Red are:

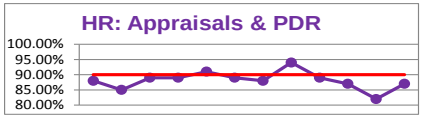
- 2 x Finance reported separately via the Finance Report
- 2 x Caesarean Section (Total and Elective) at 28% and 14% respectively (Target <= 23% and < 10% respectively)
- Maternity Triage within 30 minutes at 91% (Target >= 95%)
- Maternity: Epidurals not given for non-clinical reasons at 6.09% (Target <= 5%)
- Total number of Complaints received in month at 18 (target <= 15)

The KPIs rated as Amber are:

- HR: Appraisals/PDR at 87% (Target >= 90%
- HR: Mandatory Training Rate at 94% (Target >= 95%)
- HR: Turnover Rates at 14% (Target <= 10%)
- Last minute Cancelled Op for non-clinical reasons at 5% (Target <= 4%)

Performance Summary - Trust Board - Month 4 - July 2016

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



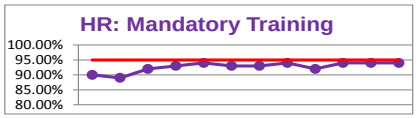
HR: Appraisals at 87% against a target of >= 90%

The overall Trust compliance rate for PDRs increased by 5% from 82% in month three to 87% in month four.

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

Managers are required to have plans in place to ensure that compliance targets are met and maintained, and these are regularly reviewed and updated. Managers have been advised they will be held accountable if compliance rates remain below target.

Although it was originally stated that the Trust would be compliant by the end of Quarter 4, 2015/16, work is on-going and should ensure compliance by the end of Quarter 2 at the latest.

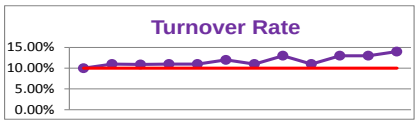


HR: Mandatory Training at 94% against a target of >= 95%

There were no significant changes at service level. There are currently ten areas rated as green as they are above the Trust target figure of 95%.

Six are as rated as amber: Gynaecology, Maternity, Medical Staff, Pharmacy, Surgical Services and Trust Offices. One is rated as red: Transport

All efforts are ongoing to reach the overall mandatory training target of 95%,. Although it was originally anticipated the target would be reached by the end of Quarter 4 2015/16, it is now predicted that it will be achieved by the end of Quarter 2 at the latest.



HR: Staff Turnover rate at 14% against a target of <= 10%

Overall, only three areas are below the Trust target figure of 10% and therefore rated as green. These are Hewitt Centre, Integrated Admin and Maternity. The remaining 14 areas are all rated as red.

Managers are provided with detailed information on turnover by the Human Resources Department so that they can monitor any concerns.

Information from the 2015 NHS Staff Survey, the PULSE survey results and exit interviews will be analysed to help identify any trust wide or local issues that may need to be addressed. The potential impact of Future Generations will continue to be monitored.

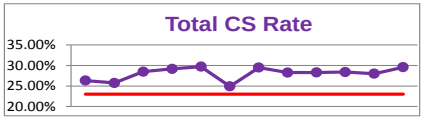
The turnover figure for the Trust has been consistently above target since September 2015. IIt was originally anticipated that the Turnover Rate would fall back below the 10% rate within the first half of 2016/17. However it is now apparent that this trend will continue for the foreseeable future, although the aim is to bring the figure under target by the end of Quarter 4 (March 2017).

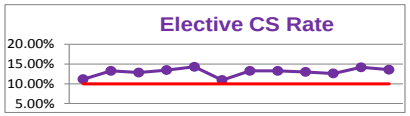
Performance Summary - Trust Board - Month 4 - July 2016

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 are being reviewed along with benchmarking of rates in other Trusts and within the Cheshire & Merseyside Strategic Clinical Network. This work is intended to inform our target rates and the findings of the review will be presented for clinical review at GACA. In the mean time, the rates will continue to be closely monitored.

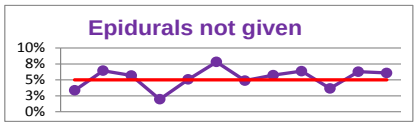
Performance Summary - Trust Board - Month 4 - July 2016

To deliver the most EFFECTIVE outcomes

There are no Red or Amber rated KPIs in this section

Performance Summary - Trust Board - Month 4 - July 2016

To deliver the best possible EXPERIENCE for patients and staff



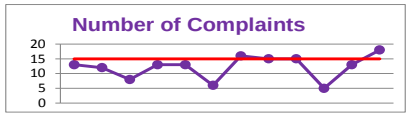
Maternity rate of Epidurals not given for non-clinical reasons at 6.09% against a target of <= 5%

In July there has been a rise in complex maternity cases, requiring consultant opinion and the requirement of opening two theatres which directly affects this performance target. 5 epidurals were not delivered due to acuity on delivery suite, 2 for anaesthetic cover issues, 1 unsuccessful attempt, 2 due to medical reasons and 15 due to women being in advanced labour.

Maternity service reported an amber performance target for 1:1 care in established labour, rising levels of acuity on delivery suite has been highlighted within the division and is reported at maternity risk.

There has been increased activity within the maternity services and a higher short term sickness rate.

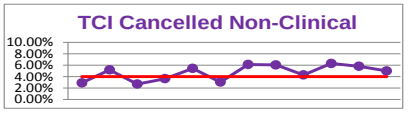
Extensive work has been undertaken in relation to medical staffing by the anaesthetic CD, to enable additional medical cover for inpatient services and it is expected that we will achieve the target rate within Quarter 2.



Number of Complaints received at 18 against a target of <= 15

The patient experience team will continue to monitor the volume of complaints received during August to ascertain whether or not this is sustained increase. The Patient Experience team will continue to promote PALS as a way of dealing with patient and family concerns.

Complaints will continue to be monitored to assess any trends over the coming month. It is expected that the target of 15 or less complaints will be achieved for August 2016.

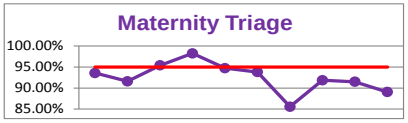


TCI's Cancelled for Non-Clinical reasons at 5% against a target of <= 4%

The target failed due to 51 patients having their TCI dates cancelled for non-clinical reasons. The majority of the cancellations are cancelled due to list changes due to procedures being brought forward or being moved to accommodate urgent cases e.g. oncology

A review of casenotes in July 2016 did not give any intelligence as the reasons for cancellations are not routinely recorded.

It is difficult to determine when the target will be achieved, due to a lack of information that would identify the issues leading to cancelled TCI's With this in mind, Admin staff have now been tasked with recording the reasons on meditech to enable more in depth analysis of the causes.



Maternity Triage within 30 Minutes at 90.17% against a target of >= 95%

Increasing complexity of women presenting at MAU requiring senior consultant opinion plus increased volume of attendance (%)has affected this target and continues to affect the triage targets.

All Linear graphs are rolling 12 months

Performance Summary - Trust Board - Month 4 - July 2016

Maternity Triage within 30 Minutes at 90.17% against a target of >= 95% (Continued)

Activity in the ipatient area in july was high and created times when inpatient beds are blocked and cannot receive patients from MAU which equally impacts on the flow of patients through the unit and the ablity to achieve the triage target.

To respond to the increased activity the MAU has change protocol for women reporting a good history of established labour will be sign posted to the appropriate intrapartum place on telephone triage. The Consultant midwife is currently reviewing the criteria for admission to MLU to ensure that intrapartum beds are available in times of high demand.

A Clear shift leadership on a shift by shift basis and clarity of roles and responsibilities with a wider understanding / acknowledgement from other clinical areas of the pressures and targets faced by the MAU i.e. MLU / DS

A deep dive into this target has been commissioned, and all clinical care reviewed and each nominated midwife on each clinical shift has had their caseload reviewed to understand where the failures to reach target have occurred, also to identify any themes or training needs. This report will be tabled for discussion at maternity risk meeting.

The escalation process and leadership on the MAU has been reviewed and the second band 7 shift leader from the delivery suite has been redeployed to lead the MAU shifts on a 24 hours per day basis to ensure that appropriate escalation is undertaken in a timely manner at all times. This change of staffing model came into effect on the 1st July 2016 .

It is expected that the target will be achieved in September 2016. this timeframe allows for recruitment to take place.

Emerging Concerns

Although it has achieved the target rate of >= 95% for July, performance against the A&E 4 Hour wait target is of continued concern as the Trust has just managed to achieve it at 95.77%, and performance has been steadily declining since April 2016. This, combined with the increase in median Arrival to Triage time from 14 to 19 minutes demonstrates that the service is under increasing pressures.

Performance Summary - Trust Board - Month 4 - July 2016

demonstrates that the service is under increasing pressures.

Conclusion

Overall, for July 2016 the Trust performance has improved in many areas, including the 6 Week Diagnostic Waits, and A&E Unplanned Reattendance rates.

However Performance against the Maternity Triage Target continues to be below the required standard. Further, performance against the HR KPI's continues to fall below their respective target rates, of most concern is the Staff Turnover Rate which in turn impacts upon the use of Agency staff to cover shifts, which at 88 shifts above the cap, is the highest rate reported thus far in 2016/17.

Pressures in A&E are beginning to manifest with a sharp increase in 4 hour wait breaches in July, and an increase in the median waiting time between arrival and Triage from 14 minutes to 19 minutes (target 15 minutes).

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

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								
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	£170								
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								
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								
Monitor: Financial Sustainability Risk Rating: Capital Cover		1	1	1	1	1								
Monitor: Financial Sustainability Risk Rating: Liquidity		2 (1 from Sep 2016)	2	2	1	1								
Monitor: Financial Sustainability Risk Rating: I & E Margin		1	1	1	1	1								
Monitor: Financial Sustainability Risk Rating: Variance to Plan		4	4	4	4	4								
Monitor: Financial Sustainability Risk Rating: Overall Score		2	1	2	2	2								
Monitor: Financial Sustainability Risk Rating: Agency Cap		0	51	25	57	88								

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%								
Elective Caesarean Section Rate		< 10%	13.00%	12.61%	14.17%	13.57%								
Safer Staffing Levels (Overall - includes Registered and Care Staff)		<= 90%	92.78%	91.92%	92.60%	91.70%								
Serious Incidents: Number of Open SI's		Monitoring Only	22	21	18	16								
Serious Incidents: Number of New SI's		Monitoring Only	1	2	4	0								
% of women seen by a midwife within 12 weeks		>= 90%	96.82%	95.44%	95.70%	94.88%								
Neonatal Bloodstream Infection Rate		TBD	0.11	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%								
Biochemical Pregnancy Rates		> 30% TBC	45.94%	47.62%	46.21%	44.70%								
Still Birth Rate (excludes late transfers)		TBD	0.00	0.01	0.01	0.01								
Neonatal Deaths (all live births within 28 days)		Rate per 1000 TBD	1.44	2.90	6.65	0.00								
Returns to Theatre		<= 0.7% TBC	0.64%	1.03%	0.50%	0.51%								

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%								
Number of Complaints received		<= 15	15	5	13	18								
18 Week RTT Incompletes (aggregate)		>= 92%	95.71%	95.90%	93.86%	95.20%								
Friends & Family Test		> 75%	99.26%	98.47%	98.60%	97.52%								
% Women that requested and Epidural, but weren't given one for non-clinical reasons		<= 5%	6.37%	3.66%	6.29%	6.04%								
% Women given one to one care whilst in established Labour (4cm dilation)		>= 95%	96.86%	96.08%	94.44%	95.74%								
6 Week Wait Diagnostic Tests		>= 99%	98.96%	97%	98%	100%								
Last Minute Cancellation for non-clinical reasons		<= 4%	4.30%	6.31%	5.81%	5.01%								
Last Minute Cancellation for non-clinical reasons (Not re-admitted within 28 days)		0	0	0	0	0								
Failure to ensure that sufficient appointment slots are available on Choose & Book		< 6%	Not Available	Not Available	Not Avialable	Not Avialable								

Agenda item no:	16/218

Meeting:	Board of Directors

Date:	2 September 2016

Title:	Month 4 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

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 4 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	

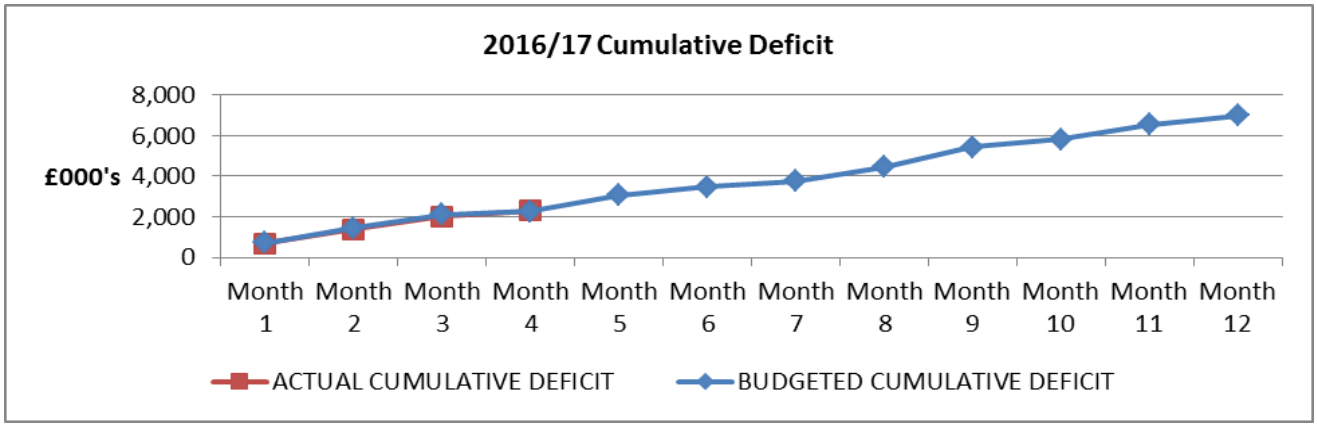
1. Executive Summary

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.

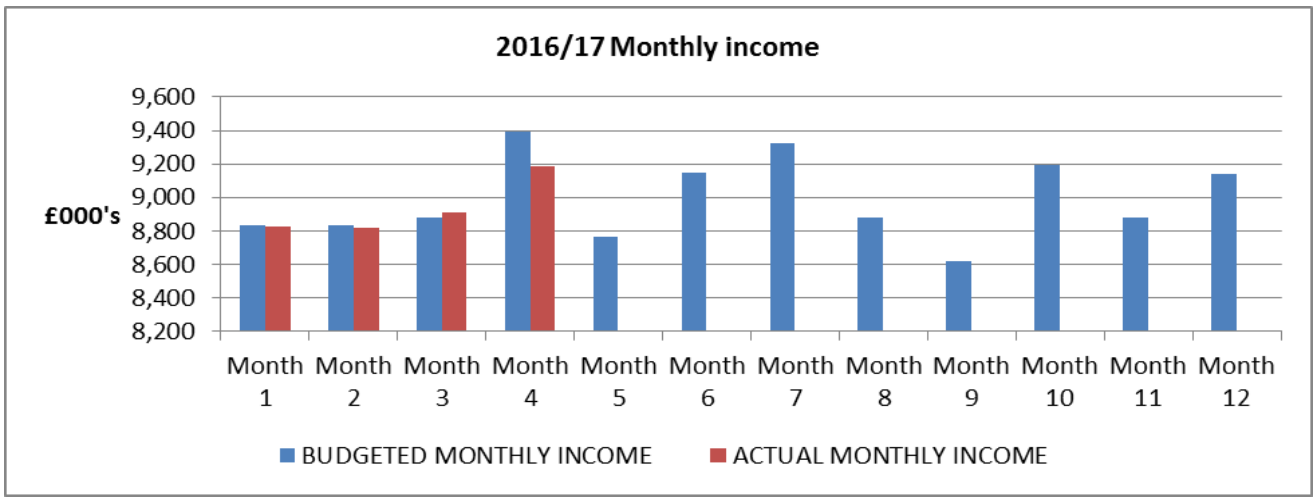
In Month 4 the Trust is reporting a monthly deficit of £0.271m against a deficit plan of £0.178 which is a negative variance of £0.093m for the month. Cumulatively the Trust is now slightly behind plan by £0.016m. The Trust achieved a Financial Sustainability Risk Rating (FSRR) of 2 against a plan of 2.

Following further detailed review in Month 4, 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.

2. Summary Financial Position



Total income in month was lower than plan, with neither maternity nor gynaecology experiencing the same levels of over achievement as seen in previous months. Month 4 has the highest income and activity target within the annual plan.



Pay expenditure remains below budget predominantly due to 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	(82)	(165)	(400)	(637)
(b) PDC + Interest Payable + Loans Repaid	700	646	2,712	2,554
CSC Ratio = (a) / (b)	**(0.12)**	**(0.25)**	**(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	(3,268)	(4,524)	(8,924)	(8,924)
(b) Expenditure	36,029	35,917	108,297	107,919
(c) Daily Expenditure	300	299	301	300
Liquidity Ratio = (a) / (c)	**(11)**	**(15)**	**(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	2,282	2,298	7,000	7,000
Total Income	(35,944)	(35,745)	(107,887)	(107,272)
I&E Margin	**-6.35%**	**-6.43%**	**-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	-6.35%	-6.43%	-6.49%	-6.53%
I&E Variance Margin	**0.83%**	**-0.08%**	**0.83%**	**-0.04%**
MONITOR I&E MARGIN VARIANCE SCORE	4	3	4	3
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 4 financial position are outlined below. (See appendix 1 for detailed results)

Maternity
Income across maternity is slightly below plan in month, but over plan year to date and is forecast to be £0.541m ahead by the end of the year. Deliveries continue to outperform the plan by c9% however antenatal activity was lower than expected in month.

There has been minimal increase in costs to date to deliver the additional activity. Pay costs are however expected to increase later in the year due to increments when a number of midwives reach their incremental competencies. Overall it is forecast that Maternity will deliver a net favourable result in the region of £0.157m.

Gynaecology and Theatres
Gynaecology has seen strong activity performance across general gynaecology since the start of the year. In Month 4 this continued to perform above plan but to a lesser extent. Underperformance across the oncology service has led to an overall negative income variance in month of £0.047m, however income remains £0.305m ahead of plan at Month 4 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 further mitigation is being sought to compensate for the shortfall arising from the delay in the scheme.

Overall, taking into account the non-delivery of CIP and the additional pay costs of the extra activity the forecast for gynaecology and theatres is a slight under performance of £0.019m.

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 commissioners is on a cost by case basis and the unit has seen a reduction in the amount of Welsh babies it has treated. This equates to the majority of the £0.208 income shortfall by Month 4.

This is being somewhat offset by non-recurrent underspend across pay which has arisen through vacancies.

Despite the investment into nursing staff by commissioners at the start of the financial year, the service has written to NHS England for £0.3m to support recurrent staffing requirements.

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 £0.439m behind plan with a projected £0.571m 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 4 CMC is £0.122m 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 the ten identified CIP schemes is £1m for the full year. Mitigations have been put in place in areas such as the Hewitt Centre (£0.5m) and further work is being undertaken to identify recurrent solutions for the remaining value.

A full review of CIP scheme delivery at Month 6 will be presented to FPBD.

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 cashflow for submission to NHSI and the DH each month.

The Trust has a requirement to draw down on the working capital facility in September to the value of £1m.

The cash balance at Month 4 was £4.5m. The Trust has currently paused the already limited capital program to preserve cash.

6. Sustainability and Transformation Fund (STF)

On 7 July 2016 the Trust received information on how to access the £2.8m of Sustainability and Transformational Funding from NHSI. This involves delivery of the year to date financial control total and achievement of performance targets.

The Trust met the criteria for the first payment and received £0.7m in relation to quarter 1 in August 2016.

7. Conclusion & Recommendation

The Board are asked to note the Month 4 financial position

Appendices

Appendix 1: Board Finance Pack

Board Finance Pack M4.xlsx

Future Generations

Agenda item no:	16/220

Meeting:	Board of Directors

Date:	2 September 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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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:

Audit Committee: 25 July 2016
The Audit Committee has no BAF risks for which they are accountable.

Finance, Performance & Business Development Committee: 25 July 2016
The FPBD Committee made no changes to the BAF risks for which they are accountable. A review of the risk descriptions took place at the meeting on 25th July 2016 at the request of the Board. Consideration is being given to the description of Risk 5A which may result in it being split into two elements – the outcome of not achieving the control total agreed with NHSI and the risk in relation to the actual achievement in year. The Director of Finance was asked to consider the right approach and bring back to the next committee meeting of the FPBD a restated risk.

Risk owners had been asked at the previous FPBD meeting to identify actions that would fill the assurance gaps on the BAF. The Committee noted that this work had been completed and that the Risk Team had worked with the risk owners to bring the FPBD risks on the BAF fully up to date.

The FPBD agreed the Risk Appetite statement.

Governance & Clinical Assurance Committee: 22 July 2016
The GACA Committee agreed to change the risk rating of Risk 1735 (1e on the BAF). They noted that there is a robust system in place for managing alerts, overseen by the Safety Senate. The sub-risk has been updated to reflect the fact that there is robust assurance in place and was therefore agreed that this risk be reduced in line with the sub-risk.

The Committee agreed a change in the emphasis of Risk 1739 (1h on the BAF). This had previously focussed in the Trust's CQC registration relating to the detention of persons under Mental Health Act. It was agreed that this should cover maintenance of appropriate CQC registration and compliance in its entirety.

Risk owners had been asked at the previous GACA meeting to identify actions that would fill the assurance gaps on the BAF. The Committee noted that this work had been completed and that the Risk Team had worked with the risk owners to bring the FPBD risks on the BAF fully up to date.

A workshop is being arranged for GACA following its meeting on 16 September. The Committee will review again the risk descriptions at the workshop to get assurance that they are described appropriately.

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

Putting People First Committee.
The PPF Committee has not as yet met to review the risk descriptions they are accountable for. The next meeting of the PPF is on 23 September 2016 at which this action would be undertaken together with the review of the Risk Appetite statement.

Other Issues
RSM have been 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 and considered:

- The process used to score risks and who this is carried out by to ensure there is sufficient review and challenge of scoring. This will include consideration of the assurances received by Divisional Groups in order to decide whether a risk can be managed locally, or if it requires escalation;
- The escalation process for a risk identified by the Divisions whereby it is escalated through the Committee structure and included on the BAF (if appropriate);
- Evidence of ongoing consideration of risk by relevant groups and Committees, including confirming whether risk is a standing agenda item on meeting agendas; and
- The de-escalation process for risks and how this ensures risks are reincorporated in to the relevant risk register with appropriate ownership assigned

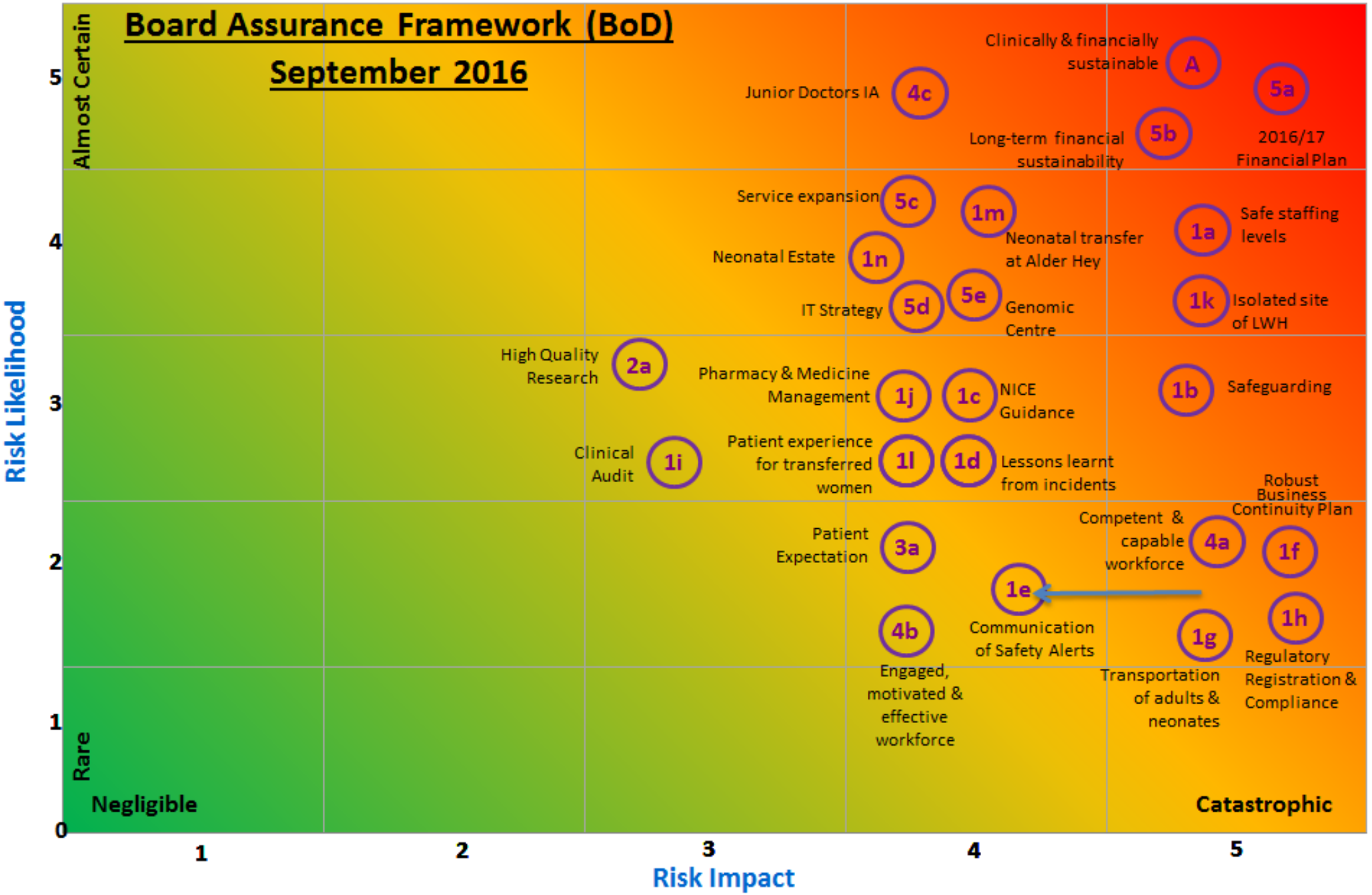
RSM will report back in early September with the findings of their audit. This will be managed through the Corporate Risk Committee.

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	**e)** To ensure appropriate and robust systems of communication and action are in place to respond to 'safety product or equipment Safety Alerts' **Risk:** Failure to ensure or respond in a timely manner to National Alerts **Cause:** Inadequate systems or processes **Effect:** Failure to communicate and enable actions to prevent harm **Impact:** May result in avoidable harm to patients and results in regulatory action brought by CQC or HSE. **Ulysses Ref: 1735.**	1597 1945 1964 1966	Risk Management Strategy	DONM (GACA)	**5X3 =15**	**4x2= 8**	•Draft CAS policy •Software system in place •Cascade system in Place •Training • Performance Reports to Clinical Governance Committee	•NPSA Alerts. (Clinical Governance Committee,13-06-2014, Item 14/15/77) •NPSA Alerts- *Early identification of failure to act on Radiological Imaging Reports.* (Clinical Governance Committee,13-06-2014, Item 14/15/78) •CAS Report- (Clinical Governance Committee,13-06-2014, Item 14/15/83 & 11-07-2014, 14/15/07) •NPSA Compliance Update- (Audit Committee, 22-09-2014. Item 14/15/29)	None		

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

	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**										
a	To deliver the financial plan beyond 2016/17 **Risk:** The Trust does not deliver its financial plan or achieve the planned continuity of services ratio of 3 in 2016/17. **Cause:** Tariff insufficiency, commissioner intentions, CNST premiums and liabilities and inability to deliver further significant CIPs **Effect: N**on-delivery of the financial plan and FSRR and reduction in available cash **Impact:** Regulatory Intervention **Ulysses Ref: 1663.**	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
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

Review of Risks

Any Other Business