Meeting of the Board of Directors
HELD IN PUBLIC
Friday 2 June 2017 at Liverpool Women's Hospital at 1000
Board Room

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard
	Thank you				1000 (5mins)	
149	Apologies for absence & Declarations of interest	Receive apologies	Verbal	Chair	1005 (10mins)	-
150	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		R17 – Good Governance
151	Board Visibility Feedback	To receive feedback from staff	Verbal	All		
152	Patient Story				1015 (20mins)	
153	Minutes of the previous meetings held on 5 May 2017 and 19 May 2017	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1035 (5mins)	R17 – Good Governance
154	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written/verbal	Chair		R17 – Good Governance
155	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1040 (15mins)	R17 – Good Governance
156	Chief Executive Report	Report key developments and announce items of significance not elsewhere	written	Chief Executive		R17 – Good Governance
BOARD ASSURANCE						

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard
157	Chair's Report from the Finance Performance and Business Development Committee	Receive assurance and any escalated risks	Written	Committee Chair	1055 (10mins)	R17 – Good Governance
158	Chair's Report from the Governance and Clinical Assurance Committee	Receive assurance and any escalated risks	Written	Committee Chair		R17 – Good Governance
159	Chairs Report from the Audit Committee	Receive assurance and any escalated risks	Written	Committee Chair		R17 – Good Governance
TRUST PERFORMANCE						
160	Performance Report period 1, 2017/18	Review the latest Trust performance report and receive assurance	Written	Director of Operations	1105 (15mins)	R12&18: Safe R17 – Good Governance
161	Finance Report period 1, 2017/18	To note the current status of the Trusts financial position	Written	Director of Finance	1120 (10mins)	R17 – Good Governance
TRUST STRATEGY						
162	Quality Strategy 2017-2020	To approve the Quality Strategy following review by GACA	Written	Medical Director	1130 (5mins)	
163	Fit for Future Generations Update	To brief the Board on progress and risks	Verbal	Chief Executive	1135 (5mins)	All
BOARD GOVERNANCE						
164	Operational Plan 2016/17 & Corporate Objectives 2016-17 close out report	To note	Written	Chief Executive	1140 (10mins)	All
165	Corporate Governance Statement	To review and approve	Written	Trust Secretary	1150 (10mins)	
166	New Board Assurance Framework & Risk Appetite Statement	To review and note status of risks	Written	Head of Governance	1200 (10mins)	
167	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1210	R17 – Good

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Fundamental Standard
					(5mins)	Governance
HOUSEKEEPING						
168	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1215 End	-

Date, time and place of next meeting Friday 7 July 2017

Meeting to end at 1215

1215-1230	Questions raised by members of the public observing the meeting on matters raised at the meeting.	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Board Agenda item 17/153(i)

Board of Directors

Minutes of the meeting of the Board of Directors
held public on Friday 5 May 2017 at 1000 hrs
in the Boardroom, Liverpool Women's Hospital, Crown Street

PRESENT

Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Mr Ian Haythornthwaite	Non-Executive Director/Vice Chair
Mrs Vanessa Harris	Director of Finance & Deputy Chief Executive
Mr Tony Okotie	Non-Executive Director/SID
Mr Ian Knight	Non-Executive Director
Dr Susan Milner	Non-Executive Director
Ms Jo Moore	Non-Executive Director
Mr Phil Huggon	Non-Executive Director
Mr David Astley	Non-Executive Director
Mrs Michelle Turner	Director of Workforce & Marketing
Dr Andrew Loughney	Medical Director
Mr Jeff Johnston	Director of Operations
Mr Doug Charlton	Director of Nursing & Midwifery
Mrs Jenny Hannon	Acting Director of Finance

IN ATTENDANCE

Mr Colin Reid	Trust Secretary
Mrs Devender Roberts	Associate Medical Director

APOLOGIES
None

Thank You
The Chair on behalf of the Board thanked the staff for their hard work and patience whilst the estate redesign work continued. He felt that the benefit to patients of the estate work would be invaluable.

113 **Patient Story**
The Chair welcomed and introduced the patient and asked her to speak to the Board on her experiences. Attending with the patient was Andrew Drakeley, Clinical Director and Chris Malone, Matron from the Hewitt Fertility Centre.

The patient explained that she was a private patient attending the Trust to receive IVF treatment. The patient praised the doctors and nurses she has encountered for their knowledge and sensitive care; however there were some improvements that would provide better quality of care to patients attending the fertility service, highlighted below:

- Better access to published statistics on success rates relating to the age of the patient;
- More evidence based information on specific tests such as Scratch, NK Cell testing and PGS

testing and their effectiveness. The patient became aware of these tests via a patient support group rather than through the Trust explaining that information from the Trust only became available once she had asked for it following her own research.

- Telephone contact with Nurses: The Patient explained that there was usually a 10-15 minute wait to be connected and on two occasions the phone has cut off and she has had to start again. Also on a number of occasions when she spoke to triage she had to wait for a call back from a nurse which when working full time was not great given access to a private are to take the call. The patient asked that consideration be given to patients who call the service to be allocated a time or be allowed to send an email. The patient suggested access to a named nurse who would be familiar with her case would be beneficial;
- Lack of communication from the Fertility Service: the patient felt that there was not enough communication from the Service and that she usually contacted the patient support group for advice. The patient explained that at times she got different information when contacting the Service which caused her some anxiety.
- Opportunity to discuss the drugs: the patient would have liked an opportunity to discuss the drugs with a doctor or nurse before they were ordered or a written document/email provided explaining why the drugs were being prescribed and what they were for.
- Long waits at the Hospital: The patient explained the she had on several occasions she had 'long waits at the Hospital', usually for scans of around 45 minutes and up to an hour. She understands there are unforeseen events which create delays however she said that this was a regular occurrence. The patient also felt at times that the staffing levels were not kept high enough to deal with these unforeseen events. The patient explained she had to wait 45 minutes for her acupuncture appointment on her first cycle transfer date; acupuncture was meant to help reduce stress but this increased the patient's stress as she had to maintain a full bladder throughout. She was told the previous patient was late so she feels that person's appointment could have been made shorter and so it did not affected subsequent patients.

The patient re-stated her praise to the doctors and nurses, who she knows are very hard working, but she felt that a better service could be provided and that perhaps private patients were being affected by underfunding in the NHS. The patient felt that this may lead private patients looking for treatment elsewhere. The patient gave high praise the patient support group run by the counsellor, John Lippitt, and patient representatives and the associated Facebook group run by patient representatives. This had been extremely useful and supportive and she would recommend this as a model throughout the Hospital and further afield.

The Chair thanked the patient for providing the Board with her experiences when using the services of the Trust and sought comments from the Board. The Medical Director referring to the telephone waiting times asked what was being done to address this. He could understand the frustration of patients when having to wait so long to speak to someone and then be told that a call back was required. The Fertility Matron advised that the Service was working on a project to improve the self-funding patient pathway. The service had also identified some areas that could be trailed without additional resource and looking at how patient calls can be dealt with quicker, identifying the possibility of having a named nurse identified for patients. The Chief Executive referred to other services in the Trust which had similar issues regarding cesses through the telephone system and suggested that learnings from those services could be taken on board. She committed the fertility service to address this concern without delay. Ian Haythornthwaite felt that a number of the issues raised today could have been dealt with when the concerns were raised and asked what had already been done to address the concerns. In response the Fertility Matron reported that a task and finish group had been set up to put in place an action plan to address the concerns; she explained that changes to the private patient pathway was currently being implemented, although at this time no permanent changes had been made. The Chief Executive advised that although these concerns had been raised by a private patient they were also relevant to NHS patients and any solutions needed to be across both sets of patients equally.

Referring to the concern over the availability of information and what was provided to patients, the Medical Director advised that it was a moral obligation for the service to provide information and this should include information on services and tests that the Trust does not undertake with the reasons why they were not undertaken. He felt it was important that patients were fully informed when using the services the Trust provided.

Referring to the Fertility website, the patient advised that the information on the site was improving to what was provided a number of years ago. She felt that more could be done to make available information on the site, with interactive information available.

The Chair thanked the patient for attending the meeting to provide her experiences. The patient thanked the Board for the opportunity to speak and explain her concerns. She said her views were only one person and that there may be conflicting views to her own. The Chief Executive recognised the concerns and advised that the patient would be appraised on how the Service would address and implement changes.

The patient left the room with the Clinical Director and Matron.

The Chair asked for any additional comments.

Ian Haythornthwaite was disappointed to hear the concerns raised and felt that the service had not acted quickly to address the concerns and this created frustrations. The Director of Operations agreed with the comments and felt that a large number of the concerns could have been addressed straight away. He advised that as the Executive responsible for the service he would pick this up with the Fertility Service Managing Director to make sure an action plan is developed and reported back to the Board. Phil Huggon noted the concerns regarding the telephone call wait times asked whether this was prevalent elsewhere in the Trust and asked if this could be investigated. Jo Moore noted the comment of the Chief Executive regarding the telephone wait times fixes put in place 5 years ago and was concerned that learning had not been disseminated across the Trust.

The Chief Executive noted the comments raised and was disappointed that the patient had not received the quality of care that would be expected for all patients using the services, whether private or NHS. She asked that the Director of Operations bring back to the Board the action plan to address the concerns and to make sure that any learnings arising from the concerns are disseminated across the Trust.

Action 2017/113: The Director of Operations to develop an action plan to address the concerns identified in the patient story (Fertility) and bring back to the Board for assurance that actions were being taken.

The Chair drew the discussion to a close and recognised the importance that the Board receive assurances that the concerns raised would be addressed.

114 Apologies – as above.

Declaration of Interests – None

115 Meeting guidance notes
The Board noted the meeting guidance notes.

116 Minutes of previous meeting held on Friday 7 April 2017
The minutes of the meeting held on 7 April 2017 were approved.

117 Matters arising and action log.

The Board noted that all actions were either complete, on the agenda or to be reported at a future meeting. Recognition was given to the date changes to conclude the actions. Referring to the Board Assurance Framework (BAF) action, the Chair noted that Governance and Clinical Assurance Committee (GACA) still needed to review the designated BAF risks before reporting the complete BAF to the Board at 2 June Board and thereafter bi monthly.

118 Chair's Announcements

The Chair made the following announcements:

Liverpool Community Health (LCH): the Chair reported on the letter received from Sir David Henshaw and Louise Shephard. He reported that the letter explained that Sir David and Louise Shephard had taken accountability for the management of Liverpool Community Health for a short period of time with Sir David and Louise Shephard assuming the Chair and Chief Executive roles at LCH and would be supported by Alder Hey.

The Chief Executive commented on the reasons for the interim arrangements and explained that following the decision of the regulator to stall the tender awards for LCH services, LCH did not have the corporate infrastructure to continue to manage the services. It was agreed by the regulators that for an interim period this would be provided by Alder Hey. More would be understood in the coming months on the approach that would be taken regarding the remaining services in LCH.

Dedicated to Excellence: The Chair thanked all the communications team who had made the event a success and congratulated the staff who had received an award. He understood the event had been a great success and was sorry he had not been able to attend.

Liverpool Health Partners: The Chair reported on future requirements to support the work of LHP. He advised that he had asked Susan Milner, as NED aligned to R&D and the Medical Director as the Executive accountable for R&D to schedule meetings with LHP once the Trust had agreed its own approach to R&D.

Council of Governors: the Chair reported on the decision of the Council to create committees to provide assurance to the Council on Patient Experience and Quality, Finance and Performance and Communications and Membership. He felt that this was an opportunity for the Governors to work in smaller groups with the support of NEDs and Executives and required commitment from all concerned to make the new structure work.

The Board noted the Chair's verbal update.

119 Chief Executive's report

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

Dedicated to Excellence: the Chief Executive referred to the list of winners in her report and congratulated not only the winners but also those staff who had been nominated. She advised that the event had always been a highlight of the year for staff who always enjoy themselves.

Retirement of Dame Lorna Muirhead: The Chief Executive referred to the retirement of Dame Lorna Muirhead as Lord Lieutenant of Cheshire and Merseyside and would therefore stepping down as patron of Trust. The Chief Executive personally thanked Dame Muirhead for her continued support of the Trust. She advised that Dame Muirhead was previously a midwife at Liverpool Women's and also a past president of the Royal College of Midwives and was an avid supporter of the work of the Trust over the years she was Patron. The Chief Executive felt she would be a great loss to the Trust and

advised that she would write to Dame Muirhead on behalf of the Board recognising her contribution and support to the Trust over the years.

Action 2017/119: The Chief Executive, on behalf of the Board, to write to Dame Muirhead thanking her for her help, support and contribution as Patron of the Trust over the years she was Patron.

The Board noted the Report from the Chief Executive.

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

Jo Moore, Chair of FPBD updated the Board on the work of the Committee at its meeting on 24 April 2017 referring in particular to the following:

- Financial position: The Committee received assurance that the Trust had delivered its 2016/17 control total, improving on the original plan by £1.3m.

- Soft FM Tender: The Committee had noted that following a robust evaluation process it was concluded that the contract for the provision of these services would be awarded to OCS Group UK Limited. The Board noted that the standstill period for the contract award had ended on 4 May 2017 and that the new contract with OCS would commence on 1 July 2017.

- Hewitt Centre update: The Committee had received a comprehensive update report from Hewitt Fertility and received assurance on the work being undertaken to stabilise the service in terms of income, activity and expenditure. The Committee noted that the more formalised Business Plan approved by the Board had been committed to be the management team within Hewitt. Jo Moore advised that the Committee had recognised the progress made over the last 6 months to deliver a business plan that was realistic in terms of its delivery. The Director of Operations advised that there was still considerable amount of work to do to keep the business on track.

- FPBD Committee Annual report 2016/17: The Committee approved the FPBD Annual Report 2016/17 which was appended to the Chair Report. Jo Moore advised that the Committee had been successful and delivered its objectives over the year. She also thanked the sub committees for their work in supporting the role of the FPBD.

Concluding her report, Jo Moore advised that 2017/18 would be a more challenging year in delivering the necessary CIP to deliver the agreed control totals. Ian Haythornthwaite referred to the report received from the Hewitt team and advised that it was a refreshing document that provided accountabilities and what could be delivered.

The Chair referring to the actions required by the Board sought the Board view on the proposals.

The Board:

- *approved the two risks that had been aligned to the Committee and the agreed risks and risk scores; the Trust is not financially sustainable beyond the current financial year [2017/18], the risk score to remain at 25; and failure to deliver the annual financial plan, the risk score to remain at 20 with a target risk score of 10 by the end of the financial year;*
- *approved the risk appetite and risk tolerance level of "moderate" against the key strategic aim, 'to be ambitious and efficient and make best use of available resources';*
- *received the FPBD Annual Report 2016/17 that supported the Annual Governance Statement 2016/17 that would be included in the Trust Annual Report and Accounts 2016/17.*

121 Chair's Report from the Putting People First Committee (PPF)

Tony Okotie, Chair of PPF updated the Board on the work of the Committee at its meeting on 28 April 2017 referring in particular to the following:

- Staff Turnover: Tony Okotie reported that after considerable challenge and debate on whether the staff turnover target should be revised for 2017/18 from 206/17 target of 10% to 13% taking into account benchmarked data both nationally and locally. He advised that the Committee had agreed to amend the target to 13%. The Director of Marketing and Workforce advised that the Trust had been out of kilter with national NHS turnover and Cheshire and Merseyside NHS providers. The Medical Director asked whether it was appropriate to revise the target whilst the rate of loss was increasing. In response Tony Okotie advised that there was considerable challenge around this particular point and the Committee had asked to be kept appraised of the position in such a competitive market.

- Marketing of LWH & Communications Strategy: Tony Okotie advised that the Committee had recognised the need to refresh the communications of the Trust's future both internally and externally; and the need for a focused marketing campaign to promote working at the Trust to support recruitment.

- Guardian of Safe Working: Tony Okotie advised that the Committee would receive regular reports from the guardian to provide the necessary assurances that the doctors were safely rostered and enable to work hours that were safe and in compliance with their contract.

- BAF and Risk Appetite: Tony Okotie referred to the amended risk score for the strategic risk 'Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust' from 10 to 15 and advised that the committee had noted and received assurance on the action plans to mitigate the risk. The Committee had also approved the risk tolerance level for 2017-18 for the key strategic aim 'To Develop a Well led, capable and motivated workforce' as moderate.

  Phil Huggon asked whether it was appropriate to undertake deep dives in service areas as part of the action plan. In response it was explained that all service areas were required to address the workforce risks; it was therefore important that there was understanding of potential issues that may arise in each service area so that any hot issues could be addressed at an early stage. Any issues found would be brought to the Committee with the relevant staff to explain the risks and what actions were being implemented to mitigate them.

The Chair referring to the actions required by the Board sought the Board view on the proposals.

The Board:

- *approved the rescoring of the BAF Workforce Risk from 10 to 15 as outlined above;*
- *approved the agreed risk tolerance level for 2017-18 for the key strategic aim 'To Develop a Well led, capable and motivated workforce' as moderate;*
- *received the Committee's Annual Report 2016/17 that supported the Annual Governance Statement 2016/17 that would be included in the Trust Annual Report and Accounts 2016/17; and*
- *approved the amendments to the Terms of Reference of the Committee*

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

122 Mortality Strategies

The Medical Director presented the Adult Mortality Strategy and Perinatal Mortality Strategy for approval. He explained that since the paper had been issued a small number of amendments to the Adult Mortality Strategy and he had received from the Clinical Director for Neonates more significant amendments to the Perinatal Mortality Strategy. The Board noted the requirement to amend both strategies and agreed to consider how it would address the amendments later in the discussion.

The Medical Director provided a presentation on mortality which included explanations on deprivation, standardised mortality rates, perinatal mortality and Board responsibilities.

Ian Haythornthwaite referring to board responsibility to have trained staff to undertake investigations asked that the Board should seek assurance from the Medical Director that the Trust had the required number of staff trained and undertaking the role. He felt that the Board needed to understand what the required number of trained staff was for a trust of the size and complexity of services and asked that a benchmarking exercise is undertaken so that the Board was assured. Ian Haythornthwaite felt that GACA should take responsibility to address this concern.

David Astley referring to mental health and learning disabilities asked whether what the process was for patients accessing the services. The Chief Executive advised that in these circumstances pregnant women would be transferred to Manchester as it had the relevant support services that were not provided at the Trust. She felt that this was a further reason for the Trust to be co-located on an adult site so where those specialist services could be provided. The Chief Executive advised that for post natal the patient would be transferred to Newcastle. She felt that in both cases this did not provide good experience for patient from Merseyside who would be away from family and friends.

Tony Okotie felt that the strategies did not give a feel of aspiration around prevention and sought clarification. The Medical Director advised that the process within the strategy would lead to prevention referring to undertaking audits, action plans and the reporting within the governance structure to the Board. He went on to advise that the greatest prevention strategy was that the Trust should not be on this site due to the clinical risks articulated in the clinical case for change. Responding to a question from the Director of Operations on how the Trust measured success, the Medical Director referred to the relevant audits and reviews that would show success through trend analysis he felt that it would be difficult to place a measure on avoidable deaths as they should not happen. Susan Milner felt that there needed to be a strengthening of the Trust ambitions and aspirations on reducing avoidable deaths and this needed greater emphasis in the strategies. David Astley agreed with the comments and felt that the Trust had to be seen as the best it can be in delivering care and its approach to quality. Phil Huggon asked whether the Medical Director could articulate two things that would reduce mortality; the Medical Director responded that he had previously articulated the need to move off the Crown Street as set out in the clinical case for change. He also felt that increased number of consultants both in adult and perinatal services would support a reduction in avoidable deaths.

The Chair asked that the Medical Director consider the comments raised and asked that he make the necessary amendments to the strategy.

The Board noted the requirements to amend the Adult Mortality Strategy and Perinatal Mortality Strategy and agreed to approve of the both strategies however that the approval would be subject to GACA review and approval of the strategies at its meeting on 15 May 2017. GACA would report back to the Board through the Chair's report its approval or otherwise.

Action 2017/122: The Medical Director to make amendments to the mortality strategies (Adult and Perinatal) and present to GACA for formal approval at its meeting on 15 May 2017.

The Chair thanked the Medical Director for his paper

123 Junior Doctors – Guardian for Safe Working Hours

The Medical Director presented the Guardian for Safe Working Hours which sets out the requirements laid down in the new junior doctors' contract. He explained that the paper had been

presented to PPF by the appointed Guardian, Mr Geoff Shaw however was unable to attend the Board due to a prior engagement.

The Medical Director drew the Board attention to the new reporting regime within the paper and the requirements for the Board and board committee, PPF, to receive reports during the year. He explained that it was the role of the Guardian to monitor and oversee exception reports and escalate where appropriate.

David Astley supported the role and felt that the Board needed to be clear that the services are supported with the right levels of staff. In this regard the Board discussed the requirements to have the right levels of staff and noted the national picture regarding the high demand for locums and the additional restrictions placed on the levels of pay which creates problems in recruiting locums.

In assessing Trust requirement for locum cover, the Chief Executive assured the Board that the executive team reviews all requirements for both agency and locum staff every week and challenges proposed requirements, she felt that there was a strong grip and control mechanism in place to manage locum requirements and advised that in all aspects the safety of the patient was paramount. The Chief Executive recognised the restrictions placed on NHS trusts by the regulator but felt that the Trust was able to manage its requirements.

The Chair thanked the Medical Director for presenting the paper and looked forward to a future report from Mr Geoff Shaw as Guardian for Safe Working Hours.

124 Quality, Operational Performance Report Period 12 2016/17

The Director of Operations presented the Quality, Operational Performance Report Period 12 2016/17 and reported all of the NHS Improvement mandatory indicators had been delivered against for the year.

David Astley asked whether the trust was keeping a grip on its elective procedures, in response the Director of Operations advised that the Trust continue to deliver against the 18 week indicator and the Trust would continue to review performance.

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

125 Financial Report & Dashboard Period 12 2016/17

The Director of Finance presented the Finance Report and financial dashboard for month 12, 2016/17 and reported that Trust had delivered its 2016/17 control total, improving on the original plan by £2.3m. At Month 12 the Trust reported a full year deficit of £4.7m against a deficit plan of £7.0m. This position includes £2.8m planned STF, as well as £1.7m of additional STF incentive and bonus funding. The Director of Finance advised that the additional STF and bonus funding received would result in the amount of uncommitted loan facility requirement in 2017/18.

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

126 Trust Operating Plan 2017-19

The Chief Executive presented the Trust's Operational Plan 2017-19 for formal ratification and advised that this plan had been the most challenging plan to bring together given the significant clinical and financial risks faced by the Trust.

The Chief Executive advised that the plan puts into context the challenges the Trust faces over the next few years and concentrated on the areas that require investment and improvement to meet the short and medium clinical risks set out in the Trust's clinical case for Change and the Liverpool CCG

PCBC, both of which had the full backing of clinicians, staff and Board. She advised that the Trust could not stand still and needed to continue to provide high quality services to meet the needs of patients.

The Chief Executive explained the areas of investment to support the clinical and safety needs of the Trust, this included investment in additional senior consultant staff and investment in the neonatal estate to provide the right size and space for the provision of care for babies in the future. The Chief Executive recognised that Crown street was a much loved site; however it was not and could not be future proofed for the services the Trust provided. She advised that as part of any changes to the estate, the changes would allow the building to be brought up to specifications so it could be used for other purposes should the Trust move.

The Director of Finance reported on the financial aspects of the Operational Plan, explaining that for 2017/18 the Trust had accepted a control total of £4.0m deficit after receipt of £3.2m of STF funding and had a cash support requirement of £4m before any capital expenditure in relation to the clinical case for change. The Director of Finance confirmed that CNST premium for the year had increased by £1.4m to £15.7m and reported on the unavoidable cost pressures. Referring to CIP the Director of Finance advised that £1.5m of schemes were not delivered in 2016/17 and explained the requirements to deliver and additional £2.2m CIP in 2017/18 on top of the undelivered 2016/17 CIP in order to deliver the control total agreed with the regulator.

Referring to the need to improve the site, the Director of Finance provided an explanation on the future investment requirements in terms of revenue items for Senior Consultant recruitment and capital items for changes to the Trust estate to support the clinical services. She concluded by stating that the Trust had a very challenging and difficult budget for 2017/18.

The Chair thanked the Chief Executive and Director of Finance for their presentations noting that the plan had gone through considerable debate and discussion at Board and with Trust clinicians and staff and sought the Boards ratification of the Plan. David Astley referring to the Maternity Community redesign project was fully supportive of the focus in this area; providing the services where patients required them. The Associate Medical Director advised that there was very good and positive consultant and midwives engagement in the community redesign project.

The Board ratified the Operational Plan 2017-19.

127 Corporate Objectives 2017-18

The Chief Executive presented the corporate objectives for 2017/18 for approval.

Susan Milner referring to the objective to “Develop the Innovation capabilities of the Trust” felt that this required further work and should be aligned to research study and the trust involvement in Liverpool Health Partners as discussed earlier in the meeting. Referring to the other two objectives under Research she felt that these were not necessarily research related objectives and should be placed elsewhere.

The Board approved the Corporate Objectives 2017/18 subject to the amendments discussed.

Action 2017/127: The Executive team to agree amendments to the corporate objectives 2017/18. The Trust Secretary to distribute the amended Corporate Objectives to the Board to make amendments to the mortality strategies (Adult and Perinatal) and present to GACA for formal approval at its meeting on 15 May 2017.

128 Fit for Future Generations Update

The Director of Workforce and Marketing explained to the Board the communications that had been

or were being developed for staff, patients and members of the public. She reported that all staff had received briefing on the fit for future generations that had been included in the Chief Executives report and explained the work around social media and the new website. The Board noted the increased communication activity but felt that more could be done when entering the hospital so that patients and service users can read what was happening and why. The Director of Workforce and Marketing advised that she would look at improving communication via bill boards for service users whilst accessing the Trust.

129 Review of risk impacts of items discussed

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

- Workforce turnover
- Locum cover
- Mortality strategies
- Delivery of operational plan and control totals

130 Any other business & Review of meeting

The Chair asked the Director of Nursing and Midwifery for his views on the meeting. In response the Director of Nursing and Midwifery felt that the Board needed to raise the profile of quality.

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

Date and time of next meeting

2 June 2017

Board Agenda item 2107/153(ii)

Board of Directors

Minutes of the meeting of the Board of Directors
held public on Friday 19 May 2017 at 1445hrs
in the Boardroom, Liverpool Women's Hospital, Crown Street

PRESENT

Mr Robert Clarke	Chair
Mr Ian Haythornthwaite	Non-Executive Director/Vice Chair
Mr Ian Knight	Non-Executive Director & Chair of Audit Committee
Mrs Vanessa Harris	Acting Chief Executive & Director of Finance
Mrs Michelle Turner	Director of Workforce & Marketing
Mr Doug Charlton	Director of Nursing & Midwifery
Mr Phil Huggon	Non-Executive Director
Dr Andrew Loughney	Medical Director
Mr Jeff Johnston	Director of Operations
Mr Tony Okotie	Non-Executive Director/SID
Mr David Astley	Non-Executive Director
Mrs Jenny Hannon	Acting Director of Finance

IN ATTENDANCE

Mr Colin Reid	Trust Secretary
Mrs Janet Parker	Finance Controller

APOLOGIES

Mrs Kathryn Thomson	Chief Executive
Ms Jo Moore	Non-Executive Director

141 **Apologies** – As above

The Chair opened the meeting and reported that the meeting had been called to approve the Annual Report and Accounts 2017. He advised that just prior to the meeting the Audit Committee had met with all the Board members in attendance, together with the internal and external auditor and key members of staff who had been involved the production of the Annual Reports and Accounts.

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

143 **Declaration of Interests**
There were no declarations of interest.

144 **Annual Report and Accounts, including Quality Report, Annual Governance Statement and Letters of Representation**
The Chair asked Ian Knight, Chair of the Audit Committee to update the Board on the discussions at the Audit Committee and the recommendations the Committee had agreed to bring to the Board.

Ian Knight, Chair of the Audit Committee reported on the discussions that had taken place at the Audit Committee. He advised that the Committee had received a draft set of papers that included the Annual Report and Accounts. He advised that the documents in the Annual Report and Accounts 2016/17 including: Forward from the Chair and Chief Executive; Performance Report; Accountability Report, which was broken down into salient sections prescribed by NHS Improvement in the FTARM guidance and including the Annual Governance Statement; Quality Report; and the Annual Accounts.

Ian Knight advised that discussion at the Committee had identified a number of suggested amendments to the reports and these would be addressed prior submission date.

Ian Knight further advised that the Committee had also received from the External Auditor, PwC the ISA 260 report which set out the key findings of the audit and included the Enhanced Audit Report 2016/17 to be included in the Annual Report and Accounts and letters of representation. He advised that the Trust, as with last year, has prepared the accounts on a going concern basis and in the statement recognises the financial challenges it faced. He advised that, again as with last year and for the same reasons, the Committee had been notified that the audit opinion contained within the Annual Report and Accounts would include an emphasis of matter statement regarding the auditors view as to why the accounts could be prepared on a going concern basis.

Referring to the audit generally, Ian Knight advised that the Audit partner was very complimentary of the work of the Trust and she had highlighted in particular the clean audit of the accounts that had not identified any concerns or issues.

Ian Knight reported that at the Committee meeting the Auditors had also presented the audit opinion and long form report for the Quality Report 2016/17. The Committee was advised that the problems encountered last year regarding 18 weeks incomplete pathway indicator had been rectified. Ian Knight advised that the Trust would receive a limited assurance audit opinion on the Quality Report and referred to the letters of representation that had also been reviewed and approved the Committee.

Ian Knight, as Chair of the Audit Committee recommended the Annual Report and Accounts 2016/17 together with the letters of representation for approval.

The Chair thanked Ian Knight for his verbal report from the Audit Committee meeting and sought the board's approval.

The Board after careful consideration of the papers presented to it and following recommendation from the Audit Committee approved the Annual Report and Accounts 2016/17, which would be subject to amendment prior to submission to NHS Improvement and approved the letters of representation. The Board noted that the final submission date for the Annual Report and Accounts to NHSI was Wednesday 31 May 2017.

145 Compliance with General Condition 6 of the Trust Provider Licence

The Trust Secretary presented the paper setting out the Trust's compliance with General Condition 6 and continuity of services 7 contained in the provider licence.

The Board approved compliance with general condition 6 and continuity of services 7. It was noted that with regards to designated commissioner requested services (CRS), the Trust provides designated CRS to NHS England; those the services provided to Liverpool CCG under contract were not categorised as designated for the purposes of the declaration.

146 Any other business

1. Future Capital requirements

The Acting Chief Executive reported that the Trust had an opportunity to bid for capital funding from the Autumn Statement in relation to bids contained within the STP. The Trust will submit a bid for £104.9m in relation to the Trust's clinical case for change as set out in the PCBC.

2. Update on the Cyber-Attack

The Chair asked the Director of Operation for a brief update on the cyber-attack that took place on Friday 12 May 2017 and its impact on patients.

The Director of Operations provided an update explaining that the Trust on receiving intelligence surrounding the possible cyber-attack from other trusts in the area implemented its emergency and resilience plan. He reported that none of the Trust's systems had been infected by the virus, reporting that the anti-virus used by the Trust had done its job.

The Director of Operations advised that the attack had been a real test for the Trust's IT continuity plans and felt that it was testament to the work of the IT team, that the Trust was able to come back on line without any integrity issues to the systems. He reported that more importantly the quality of care and patient safety was not compromised over the period.

3. Countess of Chester Hospital NHS FT

The Medical Director reported that the Trust had been alerted to a police investigation with will be investigating the deaths of fifteen babies and six non-fatal incidents between 2015 and 2016 after the Countess had contacted the police. He explained that the Countess had requested the police to undertake the investigation to rule out unnatural causes of death in its neonatal unit between June 2015 and June 2016. The Medical Director advised that if the unit were to close overnight there would be a ripple effect across the footprint however it was his understanding that the unit would not close unless the investigation found that the cause of death was unnatural.

4. Staffing and Leadership – Maternity Base

The Medical Director reported that there had been some concerns raised after a recent serious incident with respect to some clinical practice and leadership on maternity base. This is being reviewed by the SI panel. On the same day the Trust received notification from the CQC that they had received an anonymous concern regarding the same area. He advised that a review of staffing and leadership would be taking place to address concerns raised and a report would be provided to CQC.

147 **Review of risk impacts of items discussed**

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

148 **Review of meeting**

Conduct of the meeting was very good and kept to time.

The Chair thanked the Board and attendees for their diligence during the approval process.

Date and time of next meeting

Friday 2 June 2017 Boardroom

Liverpool Women's NHS Foundation Trust

2017/154

TRUST BOARD
June 2017 Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
4 Nov 2016	2016/278	Director of Nursing and Midwifery to provide an update to the board on progress made against the action plan regarding the implementation of the National Maternity Review in February 2017.	Director of Nursing and Midwifery	7 July 2017	3 March 2017 Update: An update presentation was be provided to the Board on 3 February 2017 with a formal paper presented to the Board at the 7 July 2017 meeting following the visit from Baroness Cumberlege Action ongoing.
7 Oct 2016	2016/255	The Executive Team to review the risks identified in the BAF and bring back a proposal on whether the risks can be grouped or consolidated.	Trust Secretary/Executive	Completed	See Agenda item 2017/166 on the 2 June 2017 board agenda *Previous comments: 3 February 2017 update: This action has now been superseded following the findings of the CQC mock inspection reported through GACA. A complete review of the BAF has been commissioned that would take into account not only the consolidation of the risks on the BAF (these have continued to be reviewed by the Committees) but also to consider structural changes to the way the BAF reports and manages the risks and its relationship with the Corporate Risk Register. The Executive with the support of the Chair has commissioned an external review of the BAF to make it fit for purpose and accessible by the Board, Board committees and staff.* *3 March 2017 Update: a Board workshop on the day of the April Board has been arranged to review the structure of the new BAF and risks following which the final version of the BAF will be circulated prior to being received at the 5 May 2017 meeting,* *7th April 2017 Update: Board workshop to discuss BAF following the Private Board on 7 April 2017*
5 May 2017	2017/113	The Director of Operations to develop an action plan to address the concerns identified in the patient story (Fertility) and	Director of Operations	7 July 2017	

		bring back to the Board for assurance that actions were being taken.			
5 May 2017	2017/119	The Chief Executive, on behalf of the Board, to write to Dame Muirhead thanking her for her help, support and contribution as Patron of the Trust over the years she was Patron.	Chief Executive	Complete	Letter has been sent to Dame Muirhead, thanking her for her support and contribution as patron.
5 May 2017	2017/122	The Medical Director to make amendments to the mortality strategies (Adult and Perinatal) and present to GACA for formal approval at its meeting on 15 May 2017	Medical Director	Complete	See GACA Chairs Report – Agenda item 2017/158
5 May 2017	2017/127	The Executive team to agree amendments to the corporate objectives 2017/18. The Trust Secretary to distribute the amended Corporate Objectives to the Board to make amendments to the mortality strategies (Adult and Perinatal) and present to GACA for formal approval at its meeting on 15 May 2017.	Executive Directors/Trust Secretary	Complete	Distributed amended version to the Board on 23 May 2017

		Agenda Item	**2017/156**
MEETING	**Board of Directors**		
PAPER/REPORT TITLE:	**Chief Executives Report**		
DATE OF MEETING:	2 June 2017		
ACTION REQUIRED	**For Assurance**		
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive		
AUTHOR(S):			
LINK TO STRATEGIC OBJECTIVES:	**All** Choose an item. Choose an item. Choose an item.		
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***ALL*** ***Safe:*** *Choose an item.* ***Efficient:*** *Choose an item.* ***Experience:*** *Choose an item.*	***Effective:*** *Choose an item.* ***Well Led:*** Choose an item.	
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *Choose an item.* ***Caring:*** *Choose an item.* ***Responsive:*** *Choose an item.*	***Effective:*** *Choose an item.* ***Well Led:*** *5.2 Well Led - Reg 17 Good Governance*	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)			
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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		
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***Board is asked to note the Report***		
PREVIOUSLY CONSIDERED BY:	**Committee name**	Choose an item. Or type here if not on list:	
	Agenda Ref.		
	Date of meeting		

	Summary of Outcome	Choose an item.

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

Cyber-Attack: The Trust on receiving intelligence surrounding the possible cyber-attack from other trusts in the area implemented its emergency and resilience plan. None of the Trust's systems had been infected by the virus.
The Trust had disconnected from the network as a precaution which resulted in a number of systems not being available these included: PACS/RIS, Badger Net; ICE; email; and internet. All PC's and Servers were checked over the weekend and patched if required. All systems except email were up and running on the Monday morning following the weekend, with email available from Tuesday evening. The attack had been a real test for the Trust's IT continuity plans and it was testament to the work of the IT team, that the Trust was able to come back on line without any integrity issues to the systems. More importantly the quality of care and patient safety was not compromised over the period.

The Trust has received the attached letter from Dr Anne Rainsberry, National Incident Director, NHS England regarding the UK Threat Level change from SEVERE (an attack is highly likely) to CRITICAL (an attack is expected imminently). The Trust has responded to the requests in the letter.

Neonatal Transport: The Executive Team and Board would like to say a big thank you to the Neonatal Transport Team for all their hard work and dedication to babies and their families. The service is transferring to NW Connect on 1 June 2017 and we wish them all well. A thank you lunch is taking place on 31 May 2017 on the Neonatal Unit.

SECTION B – LOCAL

Interim CEO at Southport and Ormskirk Hospital NHS Trust : Karen Jackson has been appointed interim Chief Executive of Southport and Ormskirk Hospital NHS Trust. She succeeds Iain McInnes who has been interim Chief Executive since August. He is returning to a role with NHS Improvement, the national organisation responsible for overseeing NHS provider trusts. Karen has most recently been working with NHS Improvement to lead work on improving urgent care service delivery across England. Before this she was chief executive at North Lincolnshire and Goole NHS Foundation Trust and has a professional background in NHS finance. She is a graduate in genetics from the University of Liverpool.

SECTION C – NATIONAL

Lords Select Committee reports on inquiry into NHS sustainability : A House of Lords Select Committee has published the final report of an inquiry into the long-term sustainability of the NHS.

The committee has adopted a number of the measures including longer-term financial settlement and the establishment of an independent office for health and care sustainability. The report, which also considered adult social care, criticises successive governments' 'culture of short-termism' and outlines a package of recommendations to place the health and care system on a more sustainable footing. This includes:

- Responsibility for adult social care at a national level should be transferred to a new Department of Health and Care.
- A new, independent Office for Health and Care Sustainability should be established to look at health and care needs for the next 15-20 years and report to Parliament on the impact of changing demographic needs, the workforce and skills mix in the NHS and the stability of health and social care funding relative to demand.
- Beyond 2020, a key principle of the long-term settlement for social care should be that funding increases reflect changing need and are, "as a minimum, aligned with the rate of increase for NHS funding."
- NHS England should engage with GPs to examine alternative models including direct employment
- NHS England and NHS Improvement should be merged to create a new body with simplified regulatory functions and strong local government representation.
- The government should commission an independent review to examine the impact of pay on morale and retention of health and care staff.
- The government should do more to incentivise the take-up of new approaches and make clear that there will be funding and service delivery consequences for those who repeatedly fail to engage.
- National and local public health budgets should be ring-fenced for at least the next ten years.

NHS England

NHS Provider Organisations CEO
NHS Clinical Commissioning Groups Chief Accountable Officers
Commissioning Support Units

Dr Anne Rainsberry
National EPRR Unit
NHS England
Skipton House
80 London Road
London
SE1 6LH

Publications Gateway Reference 06835

24 May 2017

Dear colleagues,

The Joint Terrorism Analysis Centre (JTAC) has advised that the UK Threat Level should be changed from **SEVERE** (an attack is highly likely) to **CRITICAL** (an attack is expected imminently). Further information regarding this change is available at https://www.mi5.gov.uk/threat-levels.

The consequence of this is that longstanding NHS Emergency Preparedness Resilience and Response (EPRR) protocol means all NHS organisations are now required please to:

- Immediately cascade the change in alert level to your staff
- Review relevant staffing levels and security arrangements across your health facilities, taking account of any additional advice from your local security experts in conjunction with the local police
- Ensure all staff are aware of your organisation's Incident Response Plans, business continuity arrangements and on call notification processes
- Ensure appropriate senior representation is available to join any NHS England Regional or Directorate of Commissioning Operations team teleconferences that may be called to brief on the situation
- Notify your local NHS England EPRR Liaison of any current or scheduled works or operational changes currently affecting service delivery within your organisation
- Review the Home Office advice issued in relation to this threat, and risk assess this against your own organisation, taking steps where possible to mitigate identified risks

- Review mutual aid agreements with other health services including specialist and private providers

Acute care providers are required to:

- Review Emergency Care, Theatre and Support Services, paying particular attention to staff availability, stocks and current blood stock levels
- Clearly identify and review patients who could be discharged safely to create capacity if your organisation is responding to an incident
- Review availability of your Patient Transport Service (PTS) particularly in the event of the local NHS Ambulance Trust requesting mutual aid from your PTS provider

Community and Mental Health providers are required to:

- Review staffing availability for crisis intervention teams
- Prepare to support any accelerated discharge from acute care settings

Clinical Commissioning Groups and Commissioning Support Units are required to:

- Act in support of accelerated discharge and where necessary support Trusts in maintaining their contracted services

NHS England will continue to work with you, the Department of Health, NHS Improvement and other government departments and agencies, and issue further advice as required.

Thank you for your leadership at this time.

Kind regards

Dr Anne Rainsberry
National Incident Director

Copy:
Tom Easterling, Director of Chair and Chief Executive Office, NHS England
Ed Rose, Chief Executive Office, NHS England
Matthew Swindells, National Director, Operations and Information, NHS England
Nicky Murphy, Head of Office, National Director Operations and Information, NHS England
Prof. Sir Bruce Keogh, Medical Director, NHS England
Prof. Jane Cummings, Chief Nurse, NHS England
Karen Wheeler, National Director Transformation and Corporate Operations, NHS England
Prof. Keith Willett, Director for Acute Care, NHS England
Dr Bob Winter, National Clinical Director EPRR, NHS England
Simon Weldon, Director of NHS Operations and Delivery, NHS England
Regional Directors, NHS England
Regional Directors of Operations and Delivery, NHS England
Simon Enright, Director of Communications, NHS England
Stephen Groves, National Head of EPRR, NHS England
National On Call Duty Officers, NHS England
National Second On Call Officers, NHS England
National Media On Call, NHS England
Ash Canavan, National EPRR Communications Lead, NHS England
Regional Heads of EPRR, NHS England
Business Continuity Team, NHS England
Jim Mackey, Chief Executive, NHS Improvement
Kathy McLean, Medical Director, NHS Improvement
Regional Managing Directors, NHS Improvement
Clair Baynton, Deputy Director of EPRR, Department of Health
Department of Health Duty Officer, Department of Health
Public Health England Duty Officer, Public Health England

2017/157

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 22 May 2017

1. Was the quorate met? Yes

2. Agenda items covered
   - ~ Month 1 2017/18 Performance Review: The Committee received month 1 2017/18 performance Dashboard in the new format agreed by the Board last month. The Committee was satisfied that the report provided it with the level of assurance it needed to assess the performance of the Trust within its terms of reference in order to assure the Board that the indicators were reviewed and challenged appropriately. The Committee noted that for month 1, 2017/18 the FPBD indicators remained strong and there was continuing work with the CCG with regard to CQUIN's to agree key deliverables in 2017/18.
   - ~ Month 1 2017/18 Finance Review: The Committee received month 1 2017/18 and noted that at Month 1 the Trust was slightly better than plan with an actual deficit of £0.550m against a plan of £0.554m.
   - ~ Cost Improvement Programme (CIP) Update: the Committee received an update on the CIP, noting that the annual CIP for the financial year was £3.7m. In the first month there was slippage in delivery of £0.079m due to slippage in three areas: capital works in inpatient redesign; MARS; and Pathology services. Following review of the CIP process committee received confirmation following the meeting that all Quality Impact Assessments and Environmental Impact Assessments had been signed off by the Medical Director and director of Nursing and Midwifery with the exception on one that needed additional work.
   - ~ Hewitt Centre Update: The committee noted progress against plan.
   - ~ Electronic Patient Record (EPR) Programme Update: the Committee received an update on progress made in the EPR programme. The Committee sought further clarification on the future governance arrangements for the EPR project across the three trusts.
   - ~ Neonatal Capital Business Case: The Committee agreed that the Neonatal Capital Business Case would be presented to the board for approval.

3. Board Assurance Framework (BAF) risks reviewed
   - ~ Board Assurance Framework (BAF): the Committee reviewed the BAF risks it is responsible for on behalf of the Board and agreed that there would be no amendments.

4. Escalation report to the Board on FPBD Performance Measures
   - ~ Activity for gynaecology for April is under plan due to reduced capacity with potential impact on 18 weeks and cancer targets.

5. Issues to highlight to Board
   - ~ No items to report.

6. Action required by Board
   - ~ To receive the Chairs Report.

Jo Moore, Chair of FPBD

2017/158

Board of Directors

Committee Chair's report of Governance and Clinical Assurance Committee meeting held 15 May 2017

1. Was the quorate met? Yes
2. Agenda items covered
   - The Committee received an update on the cyber-attack of the IT systems in the NHS from the Director of Operations. The Committee noted that the IT team had worked incredibly hard over the last few days to ensure all of the Trust's systems were not compromised and were secure and that patient safety was not compromised.
   - Medicines Management Update and Assurance: the Committee remain concerned regarding the delay in the assurance from Pharmacy relating to a specific medicines management response to the CQC Fundamental Standards and self-medication administration. Although a paper came to the meeting on self-medication it was not supported by the Chief Pharmacist or her Deputy. The Medical Director agreed to take ownership of this matter on behalf of the Committee. A report would come back to the Committee at its July meeting.
   - Serious Incident Update Report and Organisational Patient Safety Report: The Committee noted the current status of SI reporting in the Trust. Concern was expressed about the length of time action plans were taking to complete. There was recognition that some actions were poorly thought out and therefore could not be closed. The Committee asked the Medical Director and Director of Nursing and Midwifery to challenge the action plans via the Safety Senate for all outstanding SI so they are SMART and enable streamlining of the process.
   - Quality Strategy 2017-20: The Committee reviewed and approved the Quality Strategy and recommended it to the Board for approval at the June Board meeting.
   - Quality Report 2016/17: The Committee reviewed the Quality Report 2016/17 noting that it would be presented to the Board for approval at the Board meeting on 19 May 2017. The Committee was content with the report and recommended it for approval, subject to amendments that may be required following review by the external Auditor.
   - Infection Prevention and Control Annual Report 2016/17: The Committee received the DIPC report 2017 and approved it for recommendation to the Board at its July Meeting once it had been reviewed by the Safety Senate.
   - Adult Mortality Strategy and Perinatal Mortality Strategy: The Committee noted the amendments made to the strategies requested by the Board and approved the Adult Mortality Strategy and Perinatal Mortality Strategy.
   - Safety, Effectiveness & Experience Report Q4: the Committee received the SEE report and noted that consideration was being given by the Director of Nursing and Midwifery that he was considering producing a Quality Report that would be presented to the Board at each board meeting.
   - GACA Performance Indicators: The Committee received the new GACA performance indicators noting that for "Intensive Care Transfers Out" with a target of 8 transfers per year, this should be reviewed further with an aim to set the target at zero. The report set out the format that the Committee would expect to see at future meetings.
   - Board Assurance Framework and Risk Appetite Statement: the Committee, prior to the BAF being presented to the Board asked that the Executive team review in the

GACA related risks and risk scores. The Committee reviewed the Risk Appetite Statement and approved for commendation to the Board that for safety the risk appetite was LOW, for Effectiveness the risk appetite was MODERATE and for Experience the risk appetite was LOW.

- GACA Annual Report 2016/7: The Committee approved the GACA Annual Report 2016/17.

3. Board Assurance Framework (BAF) risks reviewed
   - See above
4. Escalation report to the Board on GACA Performance Measures

   Due to the date of the committee, the committee did not receive the new performance report for period 1.

5. Issues to highlight to Board

   Items to be presented to the Board
   - Adult Mortality Strategy and Perinatal Mortality Strategies had been approved by the Committee.
   - The Committee would like to draw attention to delays in closing down some outstanding SI actions
6. Action required by Board
   - Approval of the Quality Strategy 2017-20 – see agenda item 2017/162 – 2 June 2017 Board meeting.
   - Approval of the Quality Report 2016/17 [approved by the Board at its meeting on 19 May 2017].
   - Approval of the GACA BAF Risks, risk scores and appetite statement – see agenda item 2017/166– 2 June 2017 Board meeting
   - To receive the GACA Annual Report 2016/17 attached.

Susan Milner
Chair of GACA

Governance and Clinical Assurance Committee Annual Report 2015-16

Governance and Clinical Assurance Committee

The Committee is responsible for receiving assurance that the Trust has in place effective governance systems, risk management and quality improvement arrangements.

It completes these responsibilities as follows:

a. Receiving assurances in respect of the Trust's quality performance from both external and internal sources;
b. Testing assurances through 'deep dives';
c. Receiving exception reports in respect of matters of non-compliance with clinical quality, performance and risk management targets and standards;
d. Reviewing the Trust's draft quality report and receiving assurances in respect of progress against it;
e. Receiving assurance in respect of the Trust's response to national clinical guidance from external agencies;
f. Receiving the quarterly Board Statements relating to quality and governance as submitted to Monitor;
g. Reviewing the Trust's draft Research and Development strategy and receiving assurances in respect of progress against it;
h. Receiving assurances in respect of the Trust's clinical audit function.

This remit is achieved through the Committee being appropriately constituted and complying with the duties delegated by the Board of Directors through its terms of reference.

Constitution

The Governance and Clinical Assurance Committee is accountable to the Board of Directors.
Membership during the year comprised:

- Non-Executive Director (Chair)
- Two additional Non-Executive Directors (one of whom shall be Vice Chair)
- *Medical Director
- *Director of Nursing and Midwifery
- *Director of Finance
- *Director of Workforce and Marketing
- *Director of Operations (added 7 April 2017)
- *Committee Chairs of the Safe, Experience and Effectiveness Senates
- Deputy Director of Nursing and Midwifery
- Head of Governance (added 7 April 2017)

Meetings were also attended by other senior management staff as appropriate. Six meetings were held during the financial year 2016-17 – this in accordance with the frequency laid out in its terms of reference.

Key Achievements

Significant clinical and governance matters were adequately discussed with appropriate regard to risk, generating appropriate actions which were duly followed up. Key achievements are noted below:

Board Assurance Framework (BAF)
The Committee reviewed those risks assigned to it on the BAF at each of its meetings.

Risk Management Strategy
During the year the Committee has maintained a close watch and involvement in the review of Risk and Governance arrangements within the Trust. A key piece of this work was the approval of the Risk Management Strategy in January 2017. The Risk Management Strategy is complemented by assessments of the trust's Risk Management maturity using the HM Treasury Risk Management Assessment Framework.

Quality Strategy
The Quality Strategy, in conjunction with the BAF and Risk Management Strategy, form the foundation of the Quality Governance Framework. The Quality Strategy was reviewed in 2014-15 and runs until March 2017. The Committee considered progress and performance against the strategy. During 2016/17 the committee has sought the development of the new Quality Strategy 2017-2020 for approval. The strategy is currently in its final stages and will be brought to the committee in the first half of 2017/18 for approval.

Quality Report
The Committee received updates on the progress of the Quality Report in 2016-17 and will be asked to approve prior to formal approval of the Board on 19 May 2017.

Sign-up-to-Safety
In keeping with the commitments in the Quality Strategy the Committee was pleased to support the Trust's participation in the 'Sign-up to Safety' Campaign aimed at reducing the incidence of patient avoidable harm events by 50% over a three year period. The committee received regular updates from the Safety Senate regarding progress.

Clinical Assurance and Performance
The clinical performance reported in the monthly performance report prepared for the Board of Directors was reviewed by the Committee each time it met.

National Patient Safety Agency (NPSA) alerts
The Committee continued to seek assurance in respect of the Trust's compliance with National Patient Safety Agency (NPSA) alerts and noted the progress over the year.

Complaints, Litigation, Incidents & PALS
The Committee routinely considered the Trust's SEE report. This contained information on the full spectrum of Governance activity but gave the Committee particular assurance regarding the handling of complaints, litigation, incidents and Patient Advice and Liaison Service contacts.

Care Quality Commission
The Committee received regular reports detailing the Trust's position against the CQC's fundamental standards. It also monitors the Trust's response to the recommendations made following the CQC's visit to the Trust in February and March 2015. The committee also reviewed the Trust's compliance framework for future inspections.

Clinical Audit
The Committee received and noted assurances in the Clinical audit forward plan which provided assurance in respect of the Trust's programme of clinical audit and the level of engagement. The

number of audits undertaken is being managed to fit resources and ensure timely completion. The committee was further advised of the changes in the monitoring of audit via the Effectiveness Senate

Governance Meeting Structure
Agreement was reached with FPBD that two of the committees reporting committees would report through FPBD in the future they relate to Information Governance Committee and Emergency Planning Resilience & Response Committee. The Committee constantly reviews its reporting committees to be assured that it receives assurance on the work they undertake.

Safeguarding
The committee and Trust have maintained their focus on safeguarding of children and vulnerable adults during the year. As well as regular reports from the Hospital Safeguarding Board the committee received updates on the team being commissioned to provide a peer review of safeguarding services at a number of external trusts.

Infection Prevention and Control
The Committee received quarterly reports in respect of the Trust's infection prevention and control performance and also the arrangements in place to support the achievement of low rates of MRSA and C.Difficile infections. The Committee received specific updates regarding issues on the Neonatal Unit and approved changes to the BAF risks in response.

Research and Development
The Committee received the annual report detailing the Trust's research and development activities and noted the change of reporting of R&D issues, via the Effectiveness Senate.

Conclusion

In evaluating its achievements it is concluded that the Governance and Clinical Assurance Committee has achieved its objectives for the Financial Year 2016-17.

Work planned for 2017-18

- To agree a Quality Strategy for 2017-20;
- To review and recommend to the Board of Directors the 2016-17 Quality Report;
- To consider the impact of the Trust's financial position on quality of safe clinical services;
- Review of risks assigned to the Committee in the BAF and agree risk appetite statement;
- Review of details Serious Untoward Incident reports, clinical performance reports and lessons learned;
- Review assurances that the Trust has in place effective governance systems, risk management and quality improvement arrangements and identifying key concerns for the attention of the Board of Directors.
- Receive assurance on patient experience from patient surveys and review action plans arising from them.
- To review and consider the Committees Terms of Reference

Governance and Clinical Assurance Committee
May 2017

Governance and Clinical Assurance Committee
Attendance at Committee: April 2016 – March 2017

Committee Member	Job Title	May 27th 2016	July 22nd 2016	Sept 16th 2016	Nov 18th 2016	Jan 13th 2017	March 24th 2017	% attendance
Dianne Brown	Director of Nursing & Midwifery	AP	✓	✓	✓	✓	AP	67%
Allison Edis	Deputy Director of Nursing & Midwifery	✓	✓	✓	NM			100%
Julie King	Interim Deputy Director of Nursing & Midwifery	NM	✓	NM	✓	✓	✓	67%
Jeff Johnston	Director of Operations	AP	✓	✓	✓	AP*	✓	67%
Andrew Loughney	Medical Director	✓	✓	✓	✓	✓	✓	100%
Vanessa Harris	Director of Finance	AP		AP *	✓	✓	AP	33%
Michelle Turner	Director of Workforce & Marketing	✓		AP	✓	AP**	✓	50%
Susan Milner	Non Executive Director (Chair as of Nov 2016)	NM	✓	✓	✓	✓	✓	100%
Phil Huggon	Non Executive Director	✓	AP		✓	✓	✓	67%
David Astley	Non Executive Director	✓	✓	AP	✓	✓	✓	83%
Other Attendees								
Tony Okotie	Non Executive Director	✓	AP	✓	AP	✓		50%
Colin Reid	Trust Secretary			✓	✓	✓	✓	
Gregory Hope	Head of Risk, Compliance & Assurance	✓	✓	✓	✓	✓	✓	
Devender Roberts	Clinical Director Maternity			✓		✓		
Andrew Large	Head of Finance			✓ *				
Amanda McDonough	Head of Safeguarding			✓				
Jenny Hannon	Deputy Director of Finance			AP			✓	
Tim Neal	Director of Infection Prevention and Control		✓					
David Walliker	Chief Information Officer	AP	✓			AP		
John Kirwan	Clinical Director Gynaecology		✓					
Ruth Stubbs	Head of Nursing		✓					

Louise Hardman	Research & Development Manager		✓					
Mark Turner	Director of Research & Development		✓					
Robert Clarke	Chair	✓				✓		
Cath Barton	General Manager	✓				✓*		
Chris Webster	Lead Cancer Nurse				✓			

2017/159

Board of Directors

Committee Chair's report of Audit Committee meeting held 19 May 2017

1. Meeting Quorate: Yes

2. Agenda items covered

~ Code of Governance Compliance 2016/17: the Committee reviewed the outcome of a review on compliance with the code of governance and confirmed that the Trust continued to be compliant with the requirements and that the required statements had been included in the Annual Report 2016/17

~ Annual Report, Financial Accounts & Quality report 2016/17 including Annual Governance Statement – The Committee received and approved the Annual Report, Financial Accounts & Quality report 2016/17. It noted that there were a number of cosmetic amendments and insertions that would be required to be made to the Annual Report and Quality Report prior to submission to NHS Improvement. The Committee noted that GACA, who was responsible for reviewing the Quality Report, had undertaken this at its meeting on 15 May 2017 and had recommended it for Board approval. The Committee approved the Annual Reports and Accounts 2016/17 noting that the Annual Report and the Quality Report were subject to amendment and recommended them for approval at a convened meeting of the Board on 19 May 2017.

~ External Audit Findings & Management letter – Draft (ISA260) & Letters of Representation: The Committee received the External Audit ISA 260 noting that overall there was no outstanding matters from the audit. The Committee noted that as with previous years the audit opinion had been based on their belief that the Trust would continue as a going concern, but that disclosure would be required regarding uncertainties. The auditor had therefore issued an emphasis of matter paragraph in their opinion on the basis of the uncertainties that exist. Overall there were no significant outstanding matters from the audit.

3. Board Assurance Framework (BAF) risks reviewed

~ None

4. Issues to highlight to Board

~ None

5. BAF recommendations

~ None

6. Action required by Board

~ None

Agenda Item	2017/160

MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	Performance Dashboard	
DATE OF MEETING:	2 June 2017	
ACTION REQUIRED	**For Assurance**	
EXECUTIVE DIRECTOR:	Jeff Johnston, Director of Operations	
AUTHOR(S):	Jeff Johnston, Director of Operations	
LINK TO STRATEGIC OBJECTIVES:	**1. To develop a well led, capable motivated and entrepreneurial workforce** **2. To be ambitious and efficient and make best use of available resources** **5. To deliver the best possible experience for patients and staff** **3. To deliver safe services**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Safe:*** *Ineffective understanding and learning following significant events* ***Efficient:*** *Inability to deliver the best clinical outcomes for patients* ***Experience:*** *Poorly delivered positive experience for those engaging with our services*	***Effective:*** *Inability to deliver the best clinical outcomes for patients* ***Well Led:*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust*
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *1.1 Safe - Reg12 Safe care and treatment* ***Caring:*** *Choose an item.* ***Responsive:*** *Choose an item.*	***Effective:*** *Choose an item.* ***Well Led:*** *5.2 Safe - Reg 17 Good Governance*
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)	**NHS Improvement compliance**	
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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	

RECOMMENDATION: *(eg: The Board/Committee is asked to:-….)*	The Board note the content of the report	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee Putting People First Committee
	Agenda Ref.	
	Date of meeting	22 May 2017 and 28 April 2017
	Summary of Outcome	Noted

1. Introduction

The new Trust Board dashboard is attached in appendix 1 below. For further information the Finance Performance and Business Development (FPBD), Putting People First and the Governance and Clinical Assurance committee's (GACA) reports are available for review. Please note that to date only the FPBD has had opportunity to review their indicators due to the dates of committee meetings. For escalation purposes, each committee chairs report will escalate to its parent committee/Board as a matter of course any indicator that turns red.

For additional assurance there is an escalation process where an indicator has remained red for three months or amber for 6 months that indicator will be escalated to the appropriate parent committee for action. This escalation report will be provided by the informatics team.

2. Performance

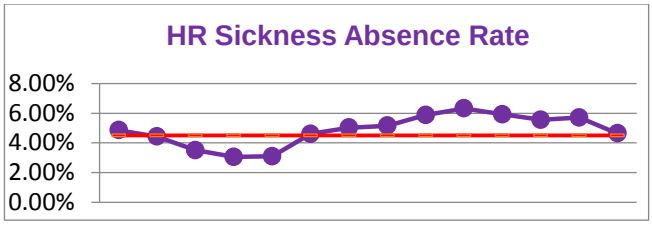
The two indicators to highlight to the Board are as follows:-

2.1 Safe Services – Never event

Retained vaginal pack - Vaginal pack and Bakri balloon were inserted on 6 April 2017. The Bakri balloon was removed later that day on the ward, the vaginal pack was not removed. The patient was discharged from the ward on 8 April and returned to the Trust on 9 April after noticing the vaginal pack. At this point the vaginal pack was removed.

This case has been reviewed and an action plan completed.

2.2 Workforce – Sickness



HR Sickness Absence Rate	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Actual	4.86%	4.42%	3.51%	3.05%	3.09%	4.61%	5.03%	5.16%	5.88%	6.32%	5.92%	5.56%	5.71%	4.64%
Target	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%

The overall single month sickness figure decreased significantly by 1.07% from 5.71% in month twelve to 4.64% in month one. This is currently 0.14% above the Trust target figure of 4.5%.

There was a significant shift in the split between short and long term sickness absence. In month twelve it was 35%/65% while in month one it was 15%/85%.

In terms of diagnoses, gastrointestinal problems dropped out of the top three most common reasons which for month one were anxiety, stress, depression and musculoskeletal problems.

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

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

Support for managers is also provided by Occupational Health, particularly in terms of advice for supporting staff off long term in returning to work.

The operations team are currently undertaking an audit of return to work interviews.

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

3. Emerging concerns

Finance, Performance and Business Development Committee

Activity for gynaecology for April is under plan due to reduced capacity for building work and annual leave of consultants over Easter. Plans were in place for extra capacity in May and the new theatre rotas' will commence on the 16th June that delivers extra capacity linked to the new inpatient and day case facility. The impact on 18 weeks and cancer targets is being closely monitored through weekly capacity meetings.

Governance and Clinical assurance Committee

GACA had previously discussed the delay in closing down the actions from SI's and this was being reviewed by the Medical Director in order to address the performance against the SI action close out indicator. Furthermore a number of SI's has recently occurred at the Trust within a short period of time together with a never event, these will require review by GACA prior to reporting to the Board.

4. Recommendation

The Board note the content of the report

Performance and Information Department
Performance Team

APPENDIX 1

Liverpool Women's NHS Foundation Trust

NHS Improvement 2017/18 Month 1 - April 2017

To be EFFICIENT and make the best use of available resources

Indicator Name	Ref	Owner of KPI	Target	Apr-17	May-17	Jun-17	Qtr1	Jul-17	Aug-17	Sep-17	Qtr2	Oct-17	Nov-17	Dec-17	Qtr3	Jan-18	Feb-18	Mar-18	Qtr4
Financial Sustainability Risk Rating: Overall Score	KPI087	Jenny Hannon	3	3															

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Target	Apr-17	May-17	Jun-17	Qtr1	Jul-17	Aug-17	Sep-17	Qtr2	Oct-17	Nov-17	Dec-17	Qtr3	Jan-18	Feb-18	Mar-18	Qtr4
Infection Control: Clostridium Difficile	KPI104 (EAS5)		1	0															
Infection Control: MRSA	KPI105 (EAS4)		0	0															
Never Events	KPI181		0	1															
NHSE / NHSI Safety Alerts Outstanding	KPI193		0	0															
Infection Control: Clostridium Difficile - infection rate	KPI320		TBC	0															
Mortality Rates: Hospital Standardised Mortality Rates (HSMR) - weekend	KPI321		TBC	not available															
Mortality Rates: Summary Hospital Mortality Indicator	KPI322		TBC	0															

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

Indicator Name	Ref	Owner of KPI	Target	Apr-17	May-17	Jun-17	Qtr1	Jul-17	Aug-17	Sep-17	Qtr2	Oct-17	Nov-17	Dec-17	Qtr3	Jan-18	Feb-18	Mar-18	Qtr4
HR: Sickness Absence Rate	KPI101	Susan Westbury	4.5%	4.64%															

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Owner of KPI	Target	Apr-17	May-17	Jun-17	Qtr1	Jul-17	Aug-17	Sep-17	Qtr2	Oct-17	Nov-17	Dec-17	Qtr3	Jan-18	Feb-18	Mar-18	Qtr4
Maximum time of 18 weeks from point of referral to treatment in aggregate - Incompletes	KPI003 (EB3)	Chris McGhee	92%	94.55%															
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	KPI030 (EB12)	Chris McGhee	85%	89.47%															
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (before re-allocation - Not RAG rated - **for monitoring purposes only**)	KPI031 (EB12)	Chris McGhee	>= 85%	77.27%															
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Numbers (if > 5, the target applies)	KPI033 (EB13)	Chris McGhee	< 5	0															
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Percentage	KPI034 (EB14)	Chris McGhee	>= 90%	No Pts Applicable															
Complaints: Number Received	KPI038	Kevin Robinson	<= 15	10															

Liverpool Women's NHS Foundation Trust

LWH Quality Schedule 2017/18 LWH Quality Schedule

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Frequency	Owner of KPI	Target 2017/18	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
18 Week RTT: Incomplete Pathway > 52 Weeks	KPI002 EBS4)			0	0											
A&E: Total Time Spent in A&E 95th percentile	KPI012 (KPI_62)	Monthly	Sharon Owens	<= 240	235											

LWH Corporate		2017/18		Month 1 - April 2017											
To deliver the most EFFECTIVE outcomes															
Indicator Name	Ref	Owner of KPI	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Intensive Care Transfers Out (Cumulative)	KPI107		8	1											

	Agenda Item	**2017/161**
MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	Month 1 2017/18 Finance Report	
DATE OF MEETING:	2 June 2017	
ACTION REQUIRED	**For Assurance**	
EXECUTIVE DIRECTOR:	Vanessa Harris, Director of Finance	
AUTHOR(S):	Jenny Hannon - Deputy Director of Finance	
LINK TO STRATEGIC OBJECTIVES:	2. To be ambitious and efficient and make best use of available resources Choose an item. Choose an item. Choose an item.	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Safe:*** *Choose an item.* ***Efficient:*** *Failure to deliver the annual financial plan* *The Trust is not financially sustainable beyond the current financial year* ***Experience:*** *Choose an item.*	***Effective:*** *Choose an item.* ***Well Led:*** Choose an item.
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *Choose an item.* ***Caring:*** *Choose an item.* ***Responsive:*** *Choose an item.*	***Effective:*** *Choose an item.* ***Well Led:*** *Choose an item.*
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)	**Operational Plan and Budgets 2017/18**	
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	To note the Month 1 2017/18 financial position	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee

		Or type here if not on list:
	Agenda Ref.	
	Date of meeting	22 May 2017
	Summary of Outcome	Noted

1. Executive Summary

The 2017/18 budget was approved at Trust Board in April 2017. This set out a control total deficit of £4m for the year after receipt of £3.2m Sustainability and Transformation Funding (STF). The control total includes £1m of agreed investment in the costs of the clinical case for change identified in the 2017/18 operational plan.

The financial plan delivers a score of 3 in 'finance and use of resources' category within the Single Oversight Framework.

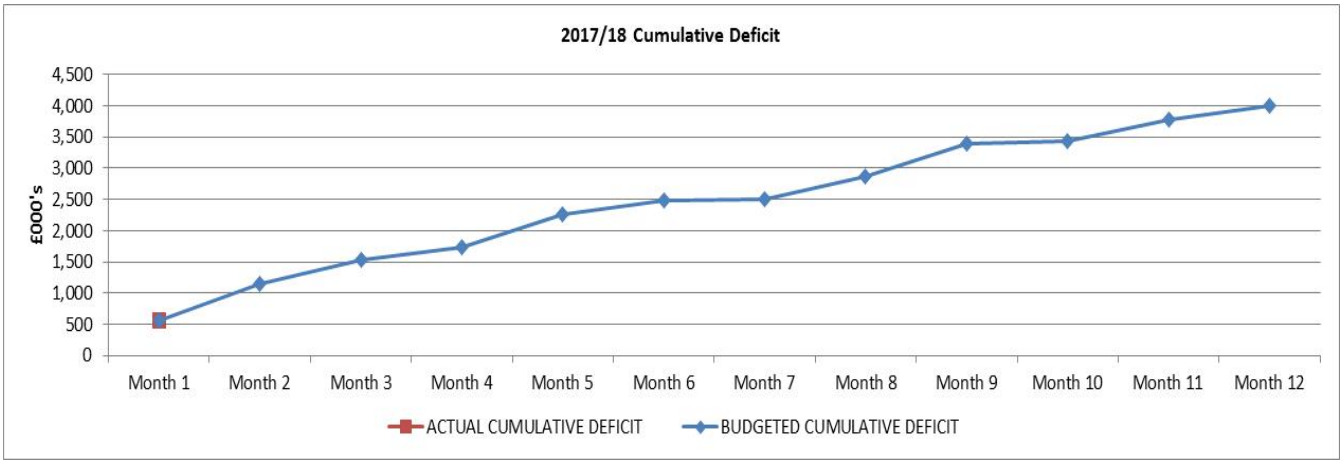
At Month 1 the Trust is slightly better than plan with an actual deficit of £0.550m against a plan of £0.554m.

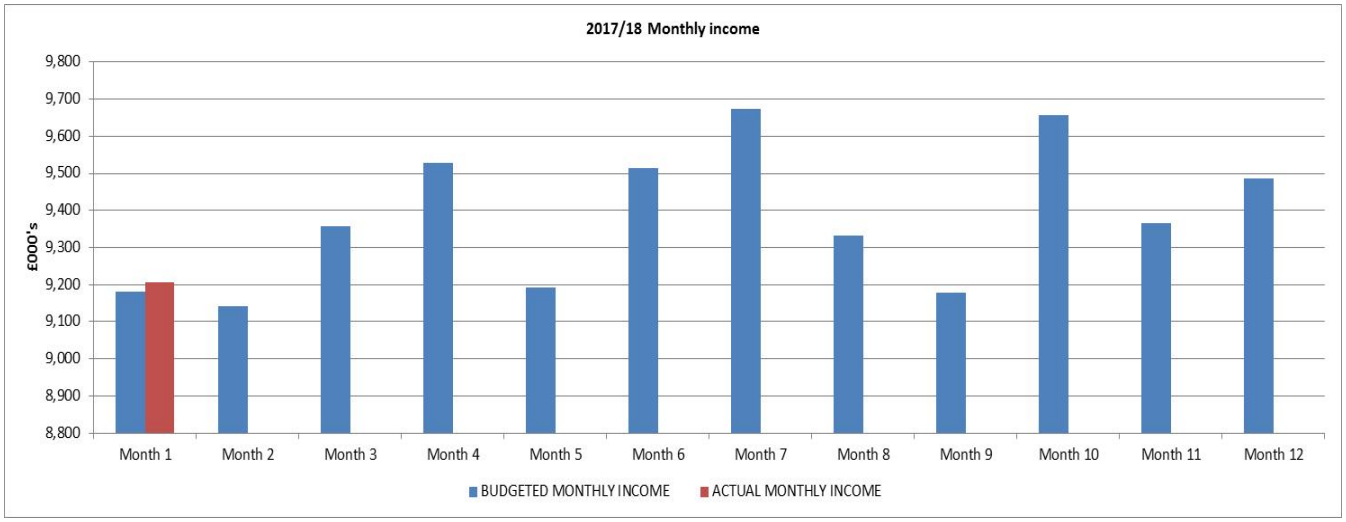
The Trust delivered a Use of Resources Rating of 3 in month which is equivalent to plan.

The monthly financial submission to NHSI is consistent with the contents of this report.

2. Month 1 2016/17 Summary Financial Position

The 2017/18 deficit is profiled below. Despite a large proportion of income being under block contract with the Trust's main commissioners, there remains an element of payment by result (PbR) in the income plan. Within the financial plan the block is profiled to reflect expected activity levels in each month.





At Month 1 income exceeded plan by £0.024m. This is as a result of overachievement against plan in Hewitt Fertility as well as neonatal transport income which continues to be received whilst the service is still delivered by the Trust. All service areas benefitted from the block arrangement with activity falling within the set income levels, however PbR activity in gynaecology was behind plan leading to a shortfall in income against budget.

Pay expenditure was slightly under budget, non-pay expenditure exceeded budget by £0.057m predominantly as a result of slippage in CIP.

The detailed position is presented in appendix one.

3. Service overview

Maternity services were favourable to budget overall, with a small income overachievement.

Gynaecology income was £0.136m behind plan. This is linked to the timing of the refurbishment of the inpatient and outpatient departments and is expected to recover in year. Nevertheless this will remain under scrutiny to ensure that all wait times and activity targets are met.

Neonates were ahead of plan largely as a result of continuing to receive income to deliver the neonatal transport service which was originally planned to cease on 1 April 2017.

Hewitt Fertility income exceeded plan by £0.113m in month and the contribution target was exceeded by £0.103m.

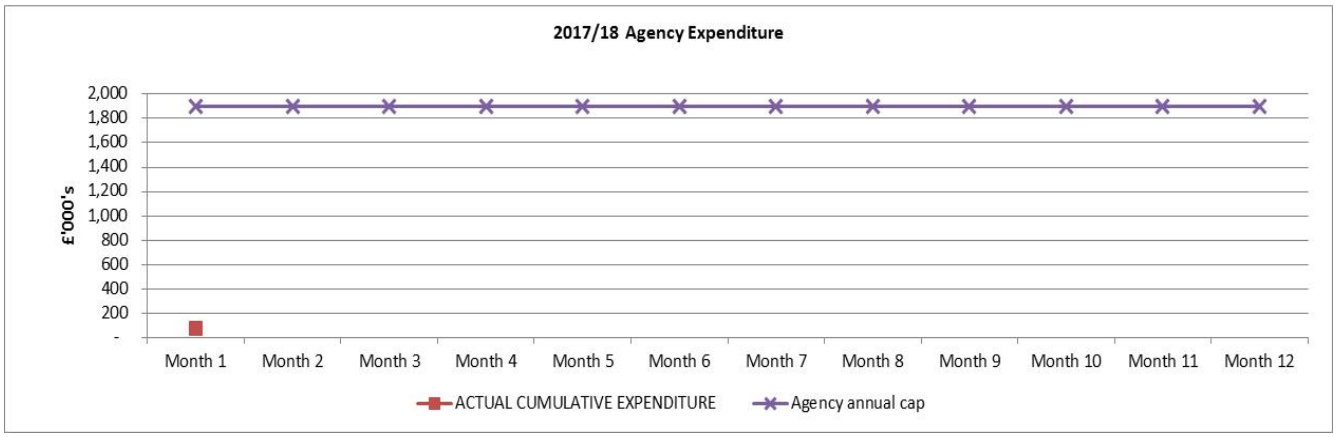
4. Month 1 CIP Delivery

The Trust has an annual CIP target of £3.7m in 2017/18. Month 1 delivery was £0.183m against a £0.262m in month target.

As identified in the operational plan, CIP delivery remains as a key risk to the delivery of the financial control total.

5. Agency Spend

The annual agency cap set by NHSI for the Trust is £1.9m. In Month 1 the Trust incurred £0.078m of agency expenditure and plans to remain within the cap for the financial year. Theatres, one of the key areas of agency usage, is effectively fully established at Month 1 with minimal agency use in month.



6. Cash and borrowings

The Trust has an operational cash borrowing requirement of £4.0m for 2017/18. The Trust continues to submit 13 week cash flow statements each month to DH, there was no requirement for a cash drawdown in Month 1.

The table below summarises the Distressed Funding borrowings to date which total £12.6m. By the end of the financial year, without any capital expenditure in relation to the clinical case requirements, the Trust will have drawn down £16.6m

Financial Year	Drawdown	Interest rate
2015/16	£5.6m	3.5%
2016/17	£7.0m	1.5%
2017/18*	£4.0m	1.5%
Total	**£16.6m**	

*planned

The Trust also has an ITFF loan of £5.5m from previous years which is being repaid at the principle sum of £0.6m per annum. The current balance outstanding on this is £4.6m with £4.0m to be carried forward into 2017/18; making the total planned operational borrowings at the end of this financial year £20.6m.

7. BAF Risk

There are no changes proposed in relation to the BAF.

8. Conclusion & Recommendation

The Board are asked to note the Month 1 financial position

Appendix 1 – Board pack

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M1

YEAR ENDED 31 MARCH 2018

Contents

1 Monitor Score

2 Income & Expenditure

3 Expenditure

4 Service Performance

5 Balance Sheet

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M1
YEAR ENDING 31 MARCH 2018

USE OF RESOURCES RISK RATING	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR Budget	YEAR FOT
CAPITAL SERVICING CAPACITY (CSC)				
(a) EBITDA + Interest Receivable	(26)	(37)	2,341	2,341
(b) PDC + Interest Payable + Loans Repaid	160	147	2,532	2,532
CSC Ratio = (a) / (b)	**(0.16)**	**(0.25)**	**0.92**	**0.92**
NHSI CSC SCORE	**4**	**4**	**4**	**4**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25				
LIQUIDITY				
(a) Cash for Liquidity Purposes	(2,933)	(940)	(2,598)	(2,598)
(b) Expenditure	9,208	9,243	110,274	110,274
(c) Daily Expenditure	307	308	306	306
Liquidity Ratio = (a) / (c)	**(9.6)**	**(3.1)**	**(8.5)**	**(8.5)**
NHSI LIQUIDITY SCORE	**3**	**2**	**3**	**3**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)				
I&E MARGIN				
Deficit (Adjusted for donations and asset disposals)	554	550	3,998	3,998
Total Income	(9,181)	(9,205)	(112,605)	(112,605)
I&E Margin	**-6.04%**	**-5.97%**	**-3.55%**	**-3.55%**
NHSI I&E MARGIN SCORE	**4**	**4**	**4**	**4**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)				
I&E MARGIN VARIANCE FROM PLAN				
I&E Margin (Actual)		-5.97%		-3.55%
I&E Margin (Plan)		-6.04%		-3.55%
I&E Variance Margin	**0.00%**	**0.07%**	**0.00%**	**0.00%**
NHSI I&E MARGIN VARIANCE SCORE	**1**	**1**	**1**	**1**
Ratio Score 1 = 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%				
AGENCY SPEND				
YTD Providers Cap	160	160	1,924	1,924
YTD Agency Expenditure	108	78	1,301	1,301
	-32.64%	**-51.35%**	**-32.38%**	**-32.38%**
NHSI AGENCY SPEND SCORE	**1**	**1**	**1**	**1**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%				
Overall Use of Resources Risk Rating	**3**	**3**	**3**	**3**

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

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M1
YEAR ENDED 31 MARCH 2018

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
Income									
Clinical Income	(8,746)	(8,714)	(32)	(8,746)	(8,714)	(32)	(106,081)	(106,081)	0
Non-Clinical Income	(436)	(491)	55	(436)	(491)	55	(6,524)	(6,524)	0
Total Income	**(9,181)**	**(9,205)**	**24**	**(9,181)**	**(9,205)**	**24**	**(112,605)**	**(112,605)**	**0**
Expenditure									
Pay Costs	5,676	5,654	22	5,676	5,654	22	67,853	67,853	0
Non-Pay Costs	2,221	2,278	(57)	2,221	2,278	(57)	26,693	26,693	0
CNST	1,311	1,311	(0)	1,311	1,311	(0)	15,728	15,728	0
Total Expenditure	**9,208**	**9,243**	**(35)**	**9,208**	**9,243**	**(35)**	**110,274**	**110,274**	**0**
EBITDA	**27**	**38**	**(12)**	**27**	**38**	**(12)**	**(2,331)**	**(2,331)**	**0**
Technical Items									
Depreciation	368	365	3	368	365	3	4,419	4,419	0
Interest Payable	36	23	13	36	23	13	432	432	0
Interest Receivable	(1)	(1)	0	(1)	(1)	0	(10)	(10)	0
PDC Dividend	124	124	0	124	124	0	1,488	1,488	0
Profit / Loss on Disposal	0	0	0	0	0	0	0	0	0
Total Technical Items	**527**	**511**	**16**	**527**	**511**	**16**	**6,329**	**6,329**	**0**
(Surplus) / Deficit	**554**	**550**	**5**	**554**	**550**	**5**	**3,998**	**3,998**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M1
YEAR ENDED 31 MARCH 2018

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	341	343	(2)	341	343	(2)	4,085	4,085	0
Medical	1,248	1,236	11	1,248	1,236	11	15,078	15,078	0
Nursing & Midwifery	2,513	2,525	(12)	2,513	2,525	(12)	30,109	30,109	0
Healthcare Assistants	416	408	8	416	408	8	4,924	4,924	0
Other Clinical	563	539	24	563	539	24	6,554	6,554	0
Admin Support	141	159	(18)	141	159	(18)	1,679	1,679	0
Corporate Services	349	366	(17)	349	366	(17)	4,125	4,125	0
Agency & Locum	106	78	28	106	78	28	1,299	1,299	0
Total Pay Costs	**5,676**	**5,654**	**22**	**5,676**	**5,654**	**22**	**67,853**	**67,853**	**0**
Non Pay Costs									
Clinical Suppplies	708	712	(4)	708	712	(4)	8,521	8,521	0
Non-Clinical Supplies	772	839	(67)	772	839	(67)	9,496	9,496	0
CNST	1,311	1,311	(0)	1,311	1,311	(0)	15,728	15,728	0
Premises & IT Costs	420	436	(16)	420	436	(16)	4,978	4,978	0
Service Contracts	322	291	30	322	291	30	3,697	3,697	0
Total Non-Pay Costs	**3,532**	**3,589**	**(57)**	**3,532**	**3,589**	**(57)**	**42,421**	**42,421**	**0**
Total Expenditure	**9,208**	**9,243**	**(35)**	**9,208**	**9,243**	**(35)**	**110,274**	**110,274**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M1
YEAR ENDED 31 MARCH 2018

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
Maternity									
Income	(3,691)	(3,722)	31	(3,691)	(3,722)	31	(45,612)	(45,612)	0
Expenditure	1,712	1,711	0	1,712	1,711	0	20,501	20,501	0
Total Maternity	**(1,980)**	**(2,011)**	**31**	**(1,980)**	**(2,011)**	**31**	**(25,110)**	**(25,110)**	**0**
Gynaecology									
Income	(2,108)	(1,972)	(136)	(2,108)	(1,972)	(136)	(25,621)	(25,621)	0
Expenditure	859	882	(23)	859	882	(23)	10,309	10,309	0
Total Gynaecology	**(1,249)**	**(1,090)**	**(159)**	**(1,249)**	**(1,090)**	**(159)**	**(15,312)**	**(15,312)**	**0**
Theatres									
Income	(42)	(40)	(1)	(42)	(40)	(1)	(499)	(499)	0
Expenditure	640	622	18	640	622	18	7,679	7,679	0
Total Theatres	**598**	**581**	**17**	**598**	**581**	**17**	**7,180**	**7,180**	**0**
Neonatal									
Income	(1,354)	(1,426)	73	(1,354)	(1,426)	73	(16,249)	(16,249)	0
Expenditure	945	956	(11)	945	956	(11)	11,341	11,341	0
Total Neonatal	**(409)**	**(470)**	**61**	**(409)**	**(470)**	**61**	**(4,908)**	**(4,908)**	**0**
Hewitt Centre									
Income	(689)	(801)	113	(689)	(801)	113	(9,971)	(9,971)	0
Expenditure	623	633	(10)	623	633	(10)	7,471	7,471	0
Total Hewitt Centre	**(66)**	**(169)**	**103**	**(66)**	**(169)**	**103**	**(2,501)**	**(2,501)**	**0**
Genetics									
Income	(600)	(528)	(73)	(600)	(528)	(73)	(7,204)	(7,204)	0
Expenditure	478	387	92	478	387	92	5,739	5,739	0
Total Genetics	**(122)**	**(141)**	**19**	**(122)**	**(141)**	**19**	**(1,465)**	**(1,465)**	**0**
Clinical Support									
Income	(26)	(33)	7	(26)	(33)	7	(295)	(295)	0
Expenditure	777	784	(7)	777	784	(7)	9,098	9,098	0
Total Clinical Support & CNST	**751**	**751**	**(0)**	**751**	**751**	**(0)**	**8,803**	**8,803**	**0**
Corporate & Trust Technical Items									
Income	(672)	(682)	10	(672)	(682)	10	(7,155)	(7,155)	0
Expenditure	3,702	3,780	(77)	3,702	3,780	(77)	44,464	44,464	0
Total Corporate	**3,030**	**3,097**	**(67)**	**3,030**	**3,097**	**(67)**	**37,310**	**37,310**	**0**
(Surplus) / Deficit	**554**	**550**	**5**	**554**	**550**	**5**	**3,998**	**3,998**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M1
YEAR ENDING 31 MARCH 2018

BALANCE SHEET £'000	YEAR TO DATE Opening	M1 Actual	Movement
Non Current Assets	**72,688**	**72,653**	(35)
Current Assets			
Cash	4,897	7,378	2,481
Debtors	8,201	7,587	(614)
Inventories	366	344	(22)
Total Current Assets	**13,464**	**15,309**	**1,845**
Liabilities			
Creditors due < 1 year	(10,577)	(12,955)	(2,378)
Creditors due > 1 year	(1,717)	(1,714)	3
Loans	(17,175)	(17,175)	0
Provisions	(3,011)	(2,996)	15
Total Liabilities	**(32,480)**	**(34,840)**	(2,360)
TOTAL ASSETS EMPLOYED	**53,672**	**53,122**	**(550)**
Taxpayers Equity			
PDC	37,420	37,420	0
Revaluation Reserve	12,233	12,233	0
Retained Earnings	4,019	3,469	(550)
TOTAL TAXPAYERS EQUITY	**53,672**	**53,122**	**(550)**

Agenda Item	2017/162

MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	**Quality Strategy**	
DATE OF MEETING:	2 June 2017	
ACTION REQUIRED	**For Decision**	
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director	
AUTHOR(S):	Amanda Cringle, Quality Improvement Lead	
LINK TO STRATEGIC OBJECTIVES:	4. To participate in high quality research in order to deliver the most effective outcomes Choose an item. Choose an item. Choose an item.	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Safe:*** *Choose an item.* ***Efficient:*** *Choose an item.* ***Experience:*** *Choose an item.*	***Effective:*** *Inability to deliver the best clinical outcomes for patients* ***Well Led:*** Choose an item.
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *Choose an item.* ***Caring:*** *Choose an item.* ***Responsive:*** *Choose an item.*	***Effective:*** *Choose an item.* ***Well Led:*** *5.2 Safe - Reg 17 Good Governance*
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)		
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***Review and approve the 2017-2020 Quality Strategy.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Governance and Clinical Assurance Committee
	Agenda Ref.	
	Date of meeting	15 May 2017

	Summary of Outcome	Recommended for Approval

1. Introduction and summary

Our vision as a trust is to be the leading provider of healthcare for women, babies and families. To deliver on this aim the trust needs to understand what quality of care it is providing and what constitutes success when analysing quality.

The Quality Strategy sets out how we at Liverpool Women's will deliver high quality care by putting patients at the centre of all we do. It is ambitious and looks to build on our successes to date. It is clear in setting out our aspiration to deliver safe and effective care for every patient whilst at the same time ensuring that they are treated with compassion, dignity and respect.

GACA will be pivotal in overseeing delivery of the strategy and ensuring momentum is maintained. This paper sets out the quality goals for the Trust for the next 3 years and details the oversight process.

2. Key Themes

The Quality Strategy was provisionally reviewed by Effectiveness Senate on 21st April. The version being considered today is the finalised version

The quality priorities for the next three years have been designed around 3 quality goals

- Reduce avoidable harm
    - Learning from incidents
    - Sepsis
    - Unplanned admissions and readmissions

- Achieve the best clinical outcomes
    - Adult Mortality
    - Neonatal mortality and Stillbirth reduction
    - Quality standards / Indicators

- Provide the best patient experience
    - Health and Wellbeing
    - Engagement
    - Learning from experience

The strategy has been designed in conjunction with the feedback received from a number of internal focus groups. Verbal feedback at the focus events was positive, particularly in regards to the fact that staff were being given an opportunity to feed into the quality priorities for the next 3 years. They also reported feeling better engaged in the direction of travel for quality at the trust and the reasons on focusing on each of the key quality themes highlighted above.

We intend to build on our performance, governance, safety and efficiency frameworks over the course of the lifetime of the strategy to create and maintain a culture of continuous quality improvement and to ensure we can be the recognised leader in healthcare for women, babies and their families.

3. Conclusions and Recommendations

It is recommended that the Committee review the attached report and approve it. GACA will monitor the effectiveness of the Strategy regularly. Regular reviews are scheduled on the Business Cycle which will look at annual implementation plans in addition to progress against the overarching three year Strategy. To assist in visualising progress a suite of indicators has been prepared to ensure the Committee understand the relevant quality metrics and what will constitute success

4. Appendix : Quality Strategy 2017-2020

Quality Strategy: 2017-2020

Liverpool Women's NHS Foundation Trust

Contents

Foreword 3
Our Trust 4
Trust Board 4
What is our Vision and what are our Aims and Values? 5
The drivers in developing the Strategy 6
Our definition of quality 6
Priorities for 2017-2020 7
Monitoring & Reporting 8
Measuring Success 18

Foreword

Our vision is to be the leading provider of healthcare for women, babies and families. Our Quality Strategy is ambitious and builds on our successes to date.

We aspire to deliver safe and effective care for every patient whilst at the same time ensuring that they are treated with compassion, dignity and respect. The Quality Strategy sets out how we at Liverpool Women's will deliver high quality care by putting patients at the centre of all we do.

Our Quality Goals are:

- Reduce avoidable harm
- Achieve the best clinical outcomes
- Provide the best patient experience

We will focus our attention on projects that will reduce avoidable harm and adult mortality, reduce stillbirths, improve patient experience and make the care that we give to our patients reliable and grounded in the foundations of evidence based care.

To achieve these challenging goals, our people will have to demonstrate unwavering determination and a commitment to quality improvement despite internal and external challenges. We will build on our performance and efficiency to create a culture of continuous quality improvement. Our goal is to become a learning organisation in which every member understands their role in delivering clinical quality and works towards that goal every day.

We will place considerable emphasis on understanding the systems, practices and behaviours that underpin clinical quality, working towards excellence in clinical systems and engaging all of our employees in improvement and learning.

Throughout the lifetime of the Strategy we will annually review and amend our quality indicators, and build on our existing governance and safety infrastructure to drive continuous improvement.

Kathryn Thomson
Chief Executive
Liverpool Women's NHS Foundation Trust

April 2017

Our Trust

Liverpool Women's NHS Foundation Trust was founded on 1st April 2005 continuing the long history of a focus on women's health services in Liverpool dating back to the 1800s. It is this continuing focus on women's health and the wider impact on families and communities that is a fundamental driver for our organisation and our future strategy.

We believe that women's health, and the health of their babies, is a specialist field, so we have brought together an outstanding range of expertise and experience in one organisation here in Liverpool. We are one of only two such specialist Trusts in the UK and the largest specialist women's hospital in Europe.

We provide a wide range of specialist women's services which are accessed at a local, regional, national and international level. We are extremely ambitious for our services and we actively work to build on our reputation for excellence, and grow our services, reputation and influence across the UK and beyond.

Each year the Trust delivers over 8,000 babies, carries out 10,000 gynaecological procedures and cares for 1,000 preterm infants on out Neonatal Unit. Our clinical services have been created and developed in response to the specific needs of the women and their families we serve.

We are constantly striving to improve and innovate for the benefit of the women and families in Liverpool and further afield, and as a result we encourage research and innovation at every level of our organisation.

Trust Board

The Trust Board is responsible for leading the organisation and ensuring the management and governance of the Trust. It is established in order to deliver sustainable, high-quality, person-centred care, support learning and innovation, and to promote an open and fair culture. The Quality Strategy is the resource by which the Trust Board:

- Sets out the definition of quality for the Trust
- Sets out our priorities for developing quality
- Defines our approach to developing a culture of continuous quality improvement in our services
- Defines our approach to assurance and governance of quality at Liverpool Women's

What is our Vision and what are our Aims and Values?

Our Vision

We will be the recognised leader in healthcare for women, babies and their families.

Our Aims – WE SEE

- To develop a well led, capable, motivated and entrepreneurial **W**orkforce
- To be ambitious and **E**fficient and make the best use of available resources
- To deliver **S**afe services
- To participate in high quality research in order to deliver the most **E**ffective outcomes
- To deliver the best possible **E**xperience for patients and staff

Our Values – we CARE and we LEARN

- **C**aring – we show we care about people
- **A**mbition – we want the best for people
- **R**espect – we value the differences and talents of people
- **E**ngaging – we involve people in how we do things
- **LEARN** – we learn from people past, present and future

The drivers in developing the Strategy

The NHS is well used to challenge and change. In addition to the challenges faced by all healthcare providers of providing high quality services in an environment of increasing demand and patient expectation at a time of financial constraint, the NHS Five Year Plan drives an increased focus on public health to relieve pressure on hospital services. Such a major transition is challenging and required courage, energy and innovation from all within the service at every level.

Locally, we have an eye to the future sustainability of our clinical services in the form of our Future Generations Strategy. We believe the services we provide are important and add value and quality to the lives of women and their families. For that reason we are actively planning our future and working closely with our colleagues in commissioning and across the healthcare sector to find the best way forward to ensure continuing focus on women's services in Liverpool.

In developing the Quality Strategy nine key themes of focus were identified under 3 overarching priorities. These themes emerged through discussion with our staff, our patients & their families, and other stakeholders and were felt to be integral to the delivery of the Trust's overall vision of being the leading healthcare provider for women, babies & their families.

In reviewing the progress of the previous Strategy, it is recognised that whilst significant progress has been made in enhancing quality improvement within the Trust further efforts are required. In maintaining the 3 overarching priorities the Trust recognises that they remain relevant and important but with the nine key themes allowing for specific key areas of focus for the future Strategy.

Part of keeping this strategy live will include holding stakeholder events for both staff and our external stakeholders. We are committed to continuously engaging commissioners, service users and staff to both hold us to account against delivery of our priority areas and help us identify new areas for each year of the strategy.

Our definition of quality

The NHS, since the publication of High Quality Care for All in 2008, has used a three-part definition of quality. NHS England describes this as:

'The single common definition of quality which encompasses three equally important parts:

- *Care that is **clinically effective** - not just in the eyes of clinicians but in the eyes of patients themselves;*
- *Care that is **safe**; and,*
- *Care that provides as positive an **experience** for patients as possible.*

High quality care is only being achieved when all three dimensions are present- not just one or two of them. And when we strive for high quality care, we must do so for everyone, including those who are vulnerable, who live in poverty and who are isolated. By seeking to deliver high quality care for all, we are striving to reduce inequalities in access to health services and in the outcomes from care.'

Priorities for 2017-2020

With High Quality Care for All at the centre of our definition of quality, the priority areas for clinical quality improvement at Liverpool Women's are aligned to these three essential dimensions. They are:

Reduce Avoidable Harm

Safety is of paramount importance to our patients and is the bottom line for Liverpool Women's when it comes to what our services must be delivering.

Key Themes

Learning from incidents
Sepsis
Unplanned Admissions & Readmissions

Achieve the best clinical outcomes

Effectiveness is providing the highest quality care, with world class outcomes whilst also being efficient and cost effective.

Key Themes

Adult mortality
Neonatal mortality & Stillbirth reduction
Quality Standards/Indicators

Provide the best Patient Experience

Our patients tell us that the **experience** they have of the treatment and care they receive on their journey through the NHS can be even more important to them than how clinically effective care has been.

Key Themes

Health and Wellbeing
Engagement
Learning from Experience

Monitoring & Reporting

The GACA Committee is responsible for providing assurance to the Board of Directors that the Trust is managing the quality of patient care, the effectiveness of clinical interventions, patient experience and patient safety. The Committee will review the quality goals at its meetings to ensure that progress is being made in relation to the key areas for improvement.

Operational Committees within the Trust will also provide specialist advice and monitoring for their dimension (see table below).

In order to track progress there will be one singe quality improvement plan that is cross referenced to other relevant quality initiatives, e.g. CQUIN, Quality Accounts etc. Progress will also be reported in the Trust's annual Quality Accounts, which will be made available on the Trust's website, NHS Choices and included in the Trust's annual report.

Measurement tools and outcome measures will be identified, developed and agreed by Quarter 1 2017 to enable quantitative monitoring in addition to work-stream updates.

Priority	Operational Lead(s)	Accountable Director	Operational Committee
Learning from incidents	Greg Hope	Director of Nursing	Safety Senate
Sepsis	Tim Neal, Ed Djabatey	Medical Director	Safety Senate
Unplanned Admissions & Readmissions	Cath Barton	Director of Operations	Safety Senate
Adult Mortality	Devender Roberts	Medical Director	Effectiveness Senate
Neonatal Mortality & Stillbirth Reduction	Devender Roberts, Bill Yoxall	Medical Director	Effectiveness Senate
Quality Standards	Devender Roberts	Medical Director	Effectiveness Senate
Staff Health & Wellbeing	Jean Annan	Director of Workforce & Marketing	Experience Senate
Engagement	Rachel London	Director of Workforce & Marketing	Experience Senate
Learning from Experience	Michelle Morgan	Director of Workforce & Marketing	Experience Senate

Learning from incidents

What do we want to achieve?

We will report and investigate incidents that could have or did harm a patient. We will inform patients, their families and our staff when we make mistakes and share any lessons we learn so that we can implement change to prevent recurrence.

Why is this important?

NHS England is clear that organisations that report more incidents usually have a better and more effective safety culture. At Liverpool Women's we firmly believe that you can't learn and improve if you don't know what the problems are. It is therefore important that patient safety incidents that could have or did harm a patient are reported so they can be learnt from. Only by doing this can we take any necessary action to prevent similar incidents from occurring in the future.

How will we achieve this?

- Take action where we identify variations in incident reporting practises between departments and staffing groups.
- Develop a never events assurance framework.
- Develop an awareness programme to increase the reporting of incidents, particularly low and no harm incidents.
- Train our staff to undertake robust root cause analysis investigations to better identify causes and contributing factors of incidents.
- Monitor actions to reduce harm, both in response to root cause analysis investigations and following thematic analysis of incidents. This will include an annual audit to ensure embedded change.

How will we know we have been successful?

☑ No never events
☑ Compliance with Duty of Candour Regulations
🡻 Year on year reduction in medication incidents resulting in harm
🡹 Year on year increase in patient safety incident reporting
🡹 Year on year increase in the proportion of near-misses and no harm incidents
☑ Remain in the upper quartile in the national reporting and learning system for patient safety incident reporting.

Sepsis

What do we want to achieve?

We will identify & treat sepsis at the earliest opportunity. We will reduce rates of hospital acquired infection and maintain them at a low level compared to other trusts.

Why is this important?

Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs. A third to half of patients who develop sepsis do not survive. Early diagnosis and treatment improves the chance of survival and recovery with MBRRACE- UK estimating that every hour delay increases the risk of death by 8%. Specifically within neonates sepsis is associated with longer hospitalisation and poorer clinical outcomes, including higher mortality, more lung and brain injury.

How will we achieve this?

- Build on our use of the sepsis 6 bundle to prevent the development and escalation of sepsis
- Continue and enhance staff education on mandatory study days and within clinical areas.
- Ensure coding for severe sepsis and septic shock are appropriate and implemented.
- Improve emergency treatment of sepsis including prompt involvement of a senior clinician.
- Review compliance with normothermy management.
- Raise staff professional awareness internal and external to the Trust through partnership working, enhanced training, study days and ward based educational sessions, and the importance of adhering to infection control practice
- Enhance support at RCA reviews to ensure there is specialised infection control input to facilitate lessons learnt and actions to prevent reoccurrence.
- Display data relating to sepsis on information boards in the clinical areas.
- Benchmarking against other similar neonatal units in the UK

How will we know we have been successful?

☑ No deaths from sepsis where the sepsis has not been identified & treated appropriately
☑ Root cause analysis of all instances of sepsis
☑ 100% Sepsis screening against the local protocol
☑ Intravenous antibiotics administered within 1 hour of presenting to all patients with severe sepsis, red flag sepsis or septic shock
⬇ Year on year reduction in instances of neonatal sepsis

Unplanned Admissions & Readmissions

What do we want to achieve?

We will strive to reduce unplanned admissions and readmissions to hospital. We will reduce rates of patients being admitted to neonatal care or returned to theatre unexpectedly.

Why is this important?

Quality of care factors are more common among readmitted than among non-readmitted patients. This suggests potential for remedial strategies and quality improvement. Preventing unplanned admissions and readmissions and unplanned escalation will have a positive impact on patient experience, will improve care coordination and reduce unnecessary spending.

How will we achieve this?

- Increased understanding of patient flow
- Planning patient discharges as early as possible and ensuring clear discharge plans are in place
- Monitoring and understanding why patients are returned to theatre unexpectedly including analysing variation as part of the revalidation process
- Targeted clinical audit
- Monitoring the factors that influence patients being returned to theatre unexpectedly
- Sharing learning from root cause analysis investigations

How will we know we have been successful?

☺ Positive patient feedback from Friends & Family Test and the National Inpatient Survey
🡻 Year on year reduction in unexpected returns to theatre
🡻 Year on year reduction in unexpected readmissions to hospital
🡻 Year on year reduction in unexpected term admissions to the neonatal unit

Adult Mortality

What do we want to achieve?

We will strive to achieve zero maternal deaths, zero unexpected deaths in women having gynaecological treatment and high quality care for women dying as an expected result of gynaecological cancer.

Why is this important?

Our isolation from other acute adult services at Liverpool Women's Hospital increases the risk to our adult patients in maternity and in gynaecology. It is important therefore that we maintain the highest possible quality of care at all times, across all of our medical, midwifery and nursing specialties. Equally important, when a woman is dying of a gynaecological cancer, we want to be sure that she is receiving the best possible care at all times as a matter of dignity and respect.

How will we achieve this?

- Introduce an Adult Mortality Strategy
- Monitor all adult deaths by introducing an audit sheet allowing the opportunity for the Trust to reflect upon the standard of care that was provided, even if this was an expected event.
- Place the family and carers at the centre of our approach to adult mortality.
- Improve oversight of mortality through discussions at local working groups, the Effectiveness Senate, Governance & Clinical Assurance Committee and Board of Directors.
- Help patients to make positive choices about the location in which they are cared for and the location where they die.
- Benchmark against other trusts to ensure our outcomes are comparable and publicly available.

How will we know we have been successful?

☑ No avoidable adult deaths
☑ No adult deaths without a completed adult mortality sheet
☑ All adult deaths subject to a mortality review
↑ Year on year increase in performance in the Annual Cancer Survey

Stillbirth & Neonatal Mortality

What do we want to achieve?

We will strive to prevent the avoidable death of any baby before or after its birth.

Why is this important?

The death of a baby before or after birth is a devastating event. Although this is sometimes unpredictable or unavoidable, in some cases, steps can be taken to reduce the chance of it happening. Bereaved women and their families also need specialist care from a dedicated team of professionals to help them through this most difficult of times.

How will we achieve this?

- Introduce a Stillbirth and Early Neonatal Death Strategy.
- Respond quickly when a woman complains of reduced movements
- Provide training to our staff in fetal heart rate monitoring
- Ensure that we are providing the best possible quality of care for women with gestational diabetes, a risk factor for stillbirth.
- Respond to evidence linking increased maternal age with stillbirth.
- Ensure that any stillbirths meeting the criteria for Each Baby Counts are reported nationally.
- Reduce the risk of early neonatal death by improving our monitoring of the baby's condition when a woman is in labour.
- Press for improvements in our neonatal unit estate that will reduce the risk of severe infections.

How will we know we have been successful?

☑ All stillbirths and neonatal deaths subject to a mortality review

🡻 Year on year reduction in avoidable stillbirth

🡻 Year on year reduction in avoidable neonatal deaths

☑ All relevant staff will be able to show evidence of recent training in fetal heart rate monitoring

☺ Year on year increase in positive feedback from our Honeysuckle Team

Quality Standards & Indicators

What do we want to achieve?

We will demonstrate compliance with evidenced based practice and will aim to be in the top performing 20% of trusts for anticipated critical outcomes

Why is this important?

Quality standards set out the priority areas for quality improvement in health and social care. They are developed independently, in collaboration with health and social care professionals, practitioners and service users. They are based on NICE guidance and other NICE-accredited sources. Increasing compliance will ensure the trust is aligned with best practice and supporting our clinicians in providing care that is evidence based and known to provide the best results.

How will we achieve this?

- Agree implementation plans for NICE Quality Standards in each division
- Audit compliance.
- Identify a suite of clinical indicators for each division, establishing baseline data.
- Develop and implement improvement plans for clinical indicators that fall outside the top 20% against appropriate peers
- Increased oversight of delivery via the Effectiveness Senate and Governance and Clinical Assurance Committee

How will we know we have been successful?

☑ Agree implementation plans for at least one NICE Quality Standard per division each year
☑ Develop a suite of clinical indicators for each division
↑ Year on year increase in performance in divisional indicators against recognised peer groups

Health & Wellbeing

What do we want to achieve?

We will strive to create a workforce that is aware of and takes ownership of how to maintain its physical and psychological welfare. This includes a culture in which leadership is focussed on the wellbeing of its staff. There will be a range of accessible and utilised facilities, information and resources to support individuals and leaders to maintain a culture of wellbeing.

Why is this important?

Maintaining staff wellbeing has a range of well documented benefits including:

- Direct positive impact on patient experience
- Promoting good physical and psychological health
- Creating healthy workplaces for staff to grow and achieve
- Allowing staff to engage with and role model healthy approaches to modern day living for patients and relatives
- Encouraging dialogue between staff regarding service improvement
- Developing leadership skills
- Reducing sickness absence
- Increasing staff effectiveness when at work
- Contributing to the achievement of Trust business objectives
- Promoting the empowerment of staff

How will we achieve this?

- Re-launch the HWB agenda
- Provide a dedicated web page with health and wellbeing information
- Display information and leaflets regarding opportunities and information
- Pilot exercise sessions in the Trust
- Promote Occupational Health availability to support individuals
- Raise the profile of mentoring
- Realign leadership programme sessions to highlight the importance of leadership to staff health and wellbeing
- Engage with staff side, volunteers, communications and the wider community for their expertise

How will we know we have been successful?

☺ Positive feedback from staff, patients and families
↑ Year on year increase in positive feedback from leadership programme reflection sessions
↑ Year on year increase in number of visits to web page
↓ Year on year reduction in sickness absence
↑ Year on year increase in staff recommending the trust as a place to work

Engagement

What do we want to achieve?

We will ensure a well led, capable, motivated and entrepreneurial workforce are in place. This will mean a culture where staff are aligned with the values and objectives of the Trust, a workforce who are motivated to deliver excellent care, a workforce who have regular opportunity to contribute ideas for improvement and who have a clear voice, a workforce who have the training and development to enable them to deliver and a workforce who feel valued and recognised. We will strive to ensure the trust has the ability to retain talented individuals.

Why is this important?

Engaged and motivated staff have a direct impact on quality of patient care and mortality rates. Management of turnover and retention of key staff is fundamental to organisational stability and engaged and motivated staff are critical to enable us to deliver challenging performance targets.

How will we achieve this?

- Build the capabilities of our managers through the Leadership Programme which will be made mandatory for targeted individuals.
- Ensure first line managers are equipped with core skills in rota management, budget management and staff management.
- Develop internal communications strategies with a focus on visibility from executive team, senior managers and local managers.
- Ensure all staff have the opportunity to contribute to quality improvement programmes in their own areas.
- Review local and trust wide reward and recognition structures, ensuring that positive feedback is formally reported.
- Audit quality of PDRs and provide support on team objective setting to operational department and ensure local objectives are aligned with organisational goals.

How will we know we have been successful?

☺ Positive feedback from staff and patients
☑ Attendance & completion of all mandatory training elements
↑ Year on year increase in the staff engagement score

Learning from Experience

What do we want to achieve?

We will promote a positive patient experience that allows the trust to deliver a high quality, carer and family experience.

Why is this important?

Delivering a positive experience is a key strategic objective for the trust and is fundamentally the right thing to do for our patients. Learning from experience is central to building and strengthening the Trust's reputation and increasing public confidence. It is what we would expect for our family and friends and has been linked to more positive clinical outcomes. The Trust is determined to get things right for our patients first time, every time.

How will we achieve this?

- Implement a new complaints policy and process in all areas of the Trust
- Increase the prominence of patient stories through all available channels
- Develop a database of all patient engagement in the Trust, establishing a baseline position from which to improve
- Use the Experience Senate to identify key issues for patients from a variety of sources to inform an annual work-plan
- Respond to themes from PALS, Complaints, and Feedback & Surveys. This will begin with improving patient access to telephone triage systems.

How will we know we have been successful?

☺ Positive feedback from staff and patients
↓ Year on year decrease in formal complaints
↓ Year on year decrease in the time taken to respond to formal complaints
↓ Year on year decrease against the thematic issue identified in each annual work-plan (e.g. triage access)
↑ Year on year increase in staff recommending the hospital as place to receive care

Measuring Success

Each priority work-stream will have an implementation plan and outcome measures aligned to the 'How will we know we have been successful?' sections. There will be one Quality Improvement plan and set of measures to track progress. The overall success of the Strategy will be measured via mechanisms, which include:

- Patient experience feedback – this will be via surveys, compliments, complaints, focus groups & patient groups
- Quality Accounts – achieving the annual priorities described in the Quality Accounts will contribute to achieving the aims of this strategy
- Mortality ratios, clinical outcomes & national clinical audits – we will continue to monitor our performance against our peers.
- Care Quality Commission – if this strategy is implemented successfully, we will obtain a minimum of a 'good' rating, aiming for 'outstanding' where possible.

A full implementation plan will be presented to the Senate providing an overview of the quality priorities and the vision for each element of quality as we progress through the lifetime of the Strategy.

	Agenda Item	**2017/164**
MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	Operational Plan 2016/17 & Corporate Objectives 2016-17 close out report	
DATE OF MEETING:	2 June 2017	
ACTION REQUIRED	**For Assurance**	
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive	
AUTHOR(S):	Michelle Turner, Director of Workforce and Marketing Colin Reid, Trust Secretary	
LINK TO STRATEGIC OBJECTIVES:	**All** Choose an item. Choose an item. Choose an item.	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***ALL*** ***Safe:*** *Choose an item.* ***Efficient:*** *Choose an item.* ***Experience:*** *Choose an item.*	***Effective:*** *Choose an item.* ***Well Led:*** Choose an item.
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***ALL*** ***Safe:*** *Choose an item.* ***Caring:*** *Choose an item.* ***Responsive:*** *Choose an item.*	***Effective:*** *Choose an item.* ***Well Led:*** *Choose an item.*
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)	**Operational Plan 2016/17 and Corporate Objectives 2016/17**	
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to note the achievements against the operational plan and corporate objectives 2016/17	

PREVIOUSLY CONSIDERED BY:	Committee name	Choose an item. Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Executive Summary

Operational Plan Corporate & Objectives Outturn 2016/17

This year the Trust has opted to use the key high level outturn results from the Operational Plan 2016/17 to promote and celebrate the achievements of the Trust and its workforce. The outturn report is presented in a simple and very visual way which will now be shared more widely internally and will be used on the website and social media. See Appendix 1.

The Corporate Objectives were approved by the Board in June 2016 and delivery against the objectives set out at appendix 2

The Board is asked to note the achievements against the operational plan and corporate objectives 2016/17

Thousands of reasons to be proud

Each year we produce an operational plan which provides clear direction for the things we aim to do. Here are some of our achievements from 2016/17 and some other facts about what our brilliant staff achieve each year…

Liverpool Women's

8,600

Babies delivered by our midwives and doctors

TV

Took part in our 3rd series of C4's One Born Every Minute, which has reached audiences of 40 million since the series began.

£

Achieved our financial control total for the year.

9,600

Gynaecology procedures were undertook

The clinical case for change was submitted to NHS England in draft form by Liverpool CCG which contains the preferred option of moving to a new hospital site in the future.

future generations

2,100

Cycles of IVF carried out at our Hewitt Fertility Centre

Shortlisted and won a number of top awards from the Royal College of Nursing, Royal College of Midwives and the NHS Leadership Academy.

1,000

Babies cared for by our Neonatal Team

Work began on modernising and refurbishing our Gynaecology wards to a Gynaecology unit to better meet patient and staff needs.

1,000

Patients recruited to clinical trails by our research team

Our outpatient facilities improvement programme began which will offer a digital self check in system and improved outpatient environment for patients and visitors.

Became the first hospital in the UK to offer bedside Neonatal Care to all babies at birth.

1st

Launched a Transformational change programme called 'Fit for Future Generations' which is looking at how we can work more effectively and efficiently.

Over 20,000 people follow us on Facebook or Twitter!

Engaged with thousands of patients and members of the public to ask what they thought the future of Liverpool Women's should look like.

Achieved our quality, safety and infection rate target , including harm and serious incident reductions aswell as zero MRSA, Cdiff, MSSA rates.

3,100

Outpatient appointments for patients with Genetic conditions

Embarked on the final stages of our paperless digital bed management programme.

50,000

Patients passed through our doors to receive care and treatment from our dedicated staff.

APPENDIX 2

STRATEGIC AIMS AND OUR CORPORATE OBJECTIVES 2016/17

The Vision, Aims and Values have been developed over a long period of time with input from the Board, Staff, Governors and Stakeholders. These were commended by both CQC and Deloitte's (when they undertook the Well Led Governance review in 2014)

Our vision:

To be the recognised leader in healthcare for women, babies and their families

Our strategic aims –
WE SEE:

W To develop a well led, capable, motivated and entrepreneurial **W**orkforce;

E To be ambitious and **E**fficient and make best use of available resources;

S To deliver **S**afe services;

E To participate in high quality research in order to deliver the most **E**ffective outcomes;

E To deliver the best possible **E**xperience for patients and staff.

Our values –
We CARE and we LEARN:

Caring – we show we care about people;
Ambition – we want the best for people
Respect – we value the differences and talents of people;
Engaging – we involve people in how we do things;
LEARN – we learn from people past, present and future.

Strategic Aim 1 - To develop a well led, capable and motivated workforce			
Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Annual Review**
Improving the Health & Wellbeing of the workforce by moving to upper quartile performance for % sickness absence and stress related absence incrementally between 2015-2018 as measured by the Annual Staff Survey	MT	Putting people First Strategy	Outputs from 2016 Annual Staff Survey demonstrated no deterioration in number of staff suffering from work related stress following a 7% reduction in staff suffering from work related stress in the previous year Stress resilience sessions delivered across maternity service. Fast track occupational health referral for mental health issues including CBT support.
Improving the organisation's climate and increasing the overall staff engagement score (as measured by Annual Staff Survey & the Staff Friends & Family Test) to upper quartile for acute specialist Trusts incrementally between 2015-2018	MT	Putting people First Strategy	Slight deterioration in overall Staff Engagement Score attributable to a reduction in staff motivation measure. Overall, no significant change in results compared to previous year set against a five year improving trend LW Leadership Programme 2016 developed and launched, with significant focus on engaging leadership & behaviours External funding secured from NHS Leadership Academy to develop Talent Management offer
Expanding the Trust's reach into its communities through extending its work experience, work training, guaranteed interview and apprenticeship schemes	MT	Putting people First Strategy	• Secured Level 2 Disability Confident status (replacement for Two Ticks) • Guaranteed interview scheme in place • Work experience programme continues to be attractive and highly evaluated – 106 students placed since April 2016 (increase on previous year) • Specialist Work Placements offered for extended periods • Care Certificate Programme rolled out • 21 staff to date completed their Apprenticeship Programme this year, 19 staff ongoing and 13 new staff enrolled. • Prepared for implementation of Apprenticeship Levy • Trust presence at School and Community Career Fairs across Liverpool • Pre-Employment programme –9 'graduates' to date of which 7 enrolled onto

			Trust Bank prior to 3 subsequently securing permanent posts within the NHS. Current cohort underway • Trust a member of the Employer Forum at Blackburne House.

Strategic Aim 2 – To be efficient and make the best use of available resources			
Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Annual Review**
Deliver the financial plan for 2016/17	VH		The Trust improved on the planned financial plan for 16/17 delivering a deficit of £4.7m against a planned deficit of £7m.
Deliver the operational plan for 2016/17	JJ		Achieve objectives in operational plan • Completed review of Future generations with FTI and the CCG • Responded to the Hewitt Centre oversight committee and delivered a full review of the service. • Mid-year secured HEE funding for additional ANNP training • The new leadership programme was developed, implemented and is in current use. • Appointed Freedom to speak guardian • Quality Strategy delivered considerable improvements • 95% of CQUINS targets achieved in CCG contract • 100k Genomes – largest recruiter in the country to the programme, however, still behind baseline plan. Working with other trusts to ensure patient numbers increase in the second half of the year and enforcing the risk sharing agreement for any underperforming Trusts. • All access targets have been achieved in the 12 months of the year. • The Trust over achieved financial targets and received STF bonus funding • Activity plans have been over achieved for Maternity, Gynaecology and Neonatal services generating additional income that offsets underachievement of CIIP schemes. • Successfully tendered the Neonatal pathology service. • Implemented electronic bed management system

Strategic Aim 3 - To deliver SAFE services			
Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Annual Review**
Maintain regulatory confidence & compliance	KT		The Trust continually keeps NHSI and CQC up to date with developments within the Trust and confidence in management and compliance is high. Regular telephone calls with NHSI on matters pertaining to the Trust's financial position and future Generations are ongoing. Recognition that the Trust is doing all things necessary to delivery sustainable services. There were no non-compliance matters raised with the Trust over the year under review.
Striving for zero avoidable harms	AL	Quality Strategy	We have reduced the number of surgical site infections to 0.68 per month against a target of 3 per month, had only one MRSA infection and no C diff infections in the last three years of reporting. In our fertility services, we have achieved one of the lowest multiple birth rates in the country at 6.3%, which reduces the risk of complications in pregnancy. Our reporting rate for no-harm medication errors has more than doubled in the last 12 months. This reflects an improving culture of safety and will help us to prevent serious incidents. The stillbirth rate has fallen by 23% for our small for gestational age babies. For preterm babies born with a very low birthweight, we have reduced the rate of late-onset bloodstream infections to 0.3 per 100 intensive care and high dependency days, against a target of 0.5.
Maintain Safe Staffing levels	DC (previously DB)	Quality & Putting People First Strategies	• Board receives Bi annual workforce assurance and review. • Monthly staffing metrics reported to the Board of Directors • Staffing red flags collected as per guidance • Operational escalation policies in place to manage workforce issues proactively • Daily fill rates monitored and reported through to NHSE. • No concerns raised during the year under review.

Maintain confidence in statutory requirements for Safeguarding Adults and Children.	DC (previously DB)	Safeguarding Strategy	• Progress has been demonstrated throughout the year in respect of developing a full suite of reviewed and ratified policies which now provides significant assurance • Similarly significant improvements in training compliance have been evidenced through the delivery of a new training programme. This has supported an increase in compliance levels, which for Safeguarding Children now reaches CQC compliance levels • Engagement continues to be evidenced in the multi-agency/ partnership working agenda • LSCB Section 11 audits in relation to the Children's Act has been completed and submitted to both Liverpool and Sefton LSCBs • Significant progress against the Safeguarding Annual Audit Tool Action Plan has been submitted with evidence of ongoing progression against outstanding actions The LWH Safeguarding Team submit quarterly Key Performance Indicator (KPI) reports to the CCG; who have now reported significant assurance in Liverpool Women's Safeguarding
Deliver zero C-diff rate and deliver improvements in the management and control of hospital acquired infections	DC (previously DB)	Quality Strategy	Achieved

Strategic Aim 4 - To deliver the most effective outcomes for Patients			
Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Annual Review**
Working in partnership with providers and commissioners to ensure quality safe services are delivered to the population of the region.	JJ	Operational Plan	• Agreed MOU with the Royal and Aintree • Agreed MOU for partnership working with LCL and Genetics • Working with the royal on sharing theatres on the crown street site. • Liverpool eye hospital operating 1 day a week on Crown street • Back office functions work stream commenced

			• Cheshire and Merseyside Women's and Children's Partnership – clinicians and managers active in networks to deliver new models of care. • Agree MOU and contract with Manchester (CMFT) for Neonatal Transport services • Agreed to work with Manchester on a joint bid for Genetics lab tender • Worked with alder Hey and the Neonatal network ODN to approve case for surgical pathway and a level two site single service level 3 unit fixed at LWH and AH. • Actively part of the LDS and STP work
Working collaboratively with clinical services deliver the objectives contained within the Quality Account	DC/AL	Quality Strategy	This is closely related to Strategic Aim 3 – zero avoidable harms, described above. To ensure the on-going achievement of the objectives contained in the Quality Account, The Clinical Audit Forward Plan (2017) has been renewed. It is now aligned with the most pressing clinical risks of the Trust, including risks relating to adult mortality. The focus is on the production of high quality work, creation and completion of SMART Action Plans, visibility of those plans at Divisional Clinical Meetings and the monitoring of relevant clinical outcome measures beyond completion of SMART Action Plans.
Development of Innovation capabilities of the Trust	AL	R&D	The Trust recognises that acting in isolation, its ability to innovate is limited. We have nevertheless opened a dialog with potential innovation partners, who have proven track records in fostering innovation in the NHS. Their proposals for partnership are currently being considered at a newly-constituted Research and Innovation leadership group in the Trust. We have also been key players in the revision of the city-wide Liverpool Health Partners' vision and are central to the present review of its strategy for improvement. Building on this, a revised Trust Research and Innovation Strategy is in production and will be completed on schedule by the end of Summer 2017.

Strategic Aim 5 - To deliver the best possible experience for patients and staff			
Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Annual Review**

Providing 'best in class' patient experience within available financial pressures	DC (previously DB)	Patient Experience Strategy	• Patient Experience strategy monitored through the Experience Senate. • National Adult Inpatient Survey 2016 -data collection complete – awaiting report due circa June 2017 • Cancer Survey 2015- reporting through GACA in November 2016. Demonstrating considerably higher scores across all domains against the national average. • Current FFT scores high at average of 98% positive recommending this as place to receive treatment and care

Overarching Strategic Aim 6 - Delivery of the Future Generation Strategy			
Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Annual Review**
Complete the strategic options review with Liverpool CCG (known as Future Generations)	VH	Future Generations	The Trust was an active participant in the Liverpool CCG strategic options review and supports the preferred outcome which was published in the CCG Pre-consultation business case. The preferred option was a relocation of services in a new building on the Central University Campus and the strengthening of neonatal services on the Alder Hey site.
Work jointly with other providers to consider future collaboration and organisational form	VH	Future Generations	During the year Aintree University Hospitals NHS Foundation Trust, Royal Liverpool and Broadgreen University Hospitals NHS Trust and Liverpool Women's NHS Foundation Trust all agreed a strategic intent to merge. For Liverpool Women's this is critical to the return to financial sustainability of women and neonatal services.
Retain Public and Staff Confidence through an effective Communications and Engagement Strategy	MT	Future Generations	Effective Comms & Engagement Strategy in situ with both internal and external focus

	Agenda Item	**2017/165**
MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	**Corporate Governance Statement – FT4**	
DATE OF MEETING:	2 June 2017	
ACTION REQUIRED	**For Decision**	
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive	
AUTHOR(S):	Colin Reid, Trust Secretary	
LINK TO STRATEGIC OBJECTIVES:	**All** Choose an item. Choose an item. Choose an item.	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***ALL - This paper relates to the Governance arrangements within the Trust*** ***Safe:*** Choose an item. ***Efficient:*** Choose an item. ***Experience:*** Choose an item.	***Effective:*** Choose an item. ***Well Led:*** Choose an item.
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *Choose an item.* ***Caring:*** *Choose an item.* ***Responsive:*** *Choose an item.*	***Effective:*** *Choose an item.* ***Well Led:*** *5.2 Safe - Reg 17 Good Governance*
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)	**NHS Improvement Compliance**	
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to consider the corporate governance statements, the evidence of compliance and following consideration the Board is asked to approve the declarations.	

PREVIOUSLY CONSIDERED BY:	Committee name	Choose an item. Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Executive Summary

NHSI revised its governance reporting requirements for trusts in 2013/14. In order to comply with both the provider licence and the Risk Assessment of their licence, the Trust is required to provide a "forward looking governance statement" in the form of a Corporate Governance Statement (CGS) to NHS Improvement. The statement, which is required to be declared by 30 June 2017, will confirm compliance with the licence condition FT4 and provide any risks to compliance with this condition during the next year and any mitigating actions it proposes to take to manage such risks.

Licence Condition FT4 - sets out the criteria that the Trust has to assess itself against when completing the Corporate Governance Statement. In addition the Trust was required to describe the ways in which it was able to assure itself of the validity of its Corporate Governance Statement in its Annual Governance Statement (AGS). The AGS was submitted with the Trust Annual Report and Accounts 2016/17 as part of the year end reporting timetable. The CGS replaces the board statements that NHS Foundation Trusts were previously required to submit with their annual plans under the FT Compliance Framework.

Additional compliance statements are also required relating to Governor Training.

The table below sets out the compliance statement (A), the Trust evidence of compliance (B), response to statement (compliant/non-compliant) (C) and any risks or mitigations.

Following approval the declarations will be placed on the Trust's website.

Recommendation

The Board is asked to consider the corporate governance statements, the evidence of compliance and following consideration the Board is asked to approve the declarations.

Corporate Governance Statement (CGS)

A=Statement within the provider licence
B= Evidence (not included in the submission)
C= Response to declaration (compliant/non-compliant)
D= Risks and mitigating actions

1.	Corporate Governance Statement A	Evidence B	Response to submission C	Risks and mitigating actions D
1	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	• NHS Improvement well-led review undertaken by Deloitte's which recognised that the Trust had principles, systems and standards of good corporate Governance in place. • CQC inspection provided the Trust with a 'good' well led rating. • Review of NHSI Code of Governance – no noncompliance issues identified • Membership of NHS Providers and the Company Secretary networks • Reviews of NHSI and other bulletins by the board and regular updates from the external auditors through the audit committee. • The Trust has an internal audit programme and assurance cycle. • External auditors provide assurance on the content of the Trust Annual Report and Accounts, the Quality Report and provide an opinion on Trust annual governance statement.	Confirmed	
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	• Trust Secretary in post, identification of any changes in guidance. • Receipt and Review of regular updates from	Confirmed	

		NHS Improvement • Membership of NW FT Company Secretary network and FTN Company Secretary Network. • Regular communications from legal advisors and internal and external auditors.		
3	The Board is satisfied that the Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	• Review of Board and Committee structure undertaken as part of well led review. Constant review of performance of Board and committee's undertaken and annual report from each committee is presented to the Board for noting. • Annual Governance statement provides the Board with assurance surrounding the responsibilities of the Board and its committees. • Board approved terms of reference of Board Committees providing details of reporting lines, responsibilities and membership. • Clear reporting lines within the Board, Executive and service areas provided through the Trusts governance framework and Workforce strategies developed in line with Trust's Vision, Aims and Value's	Confirmed	
4	The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;	a) Strong systems of financial and quality governance in place. All statutory audits and reporting requirements fulfilled via Audit Committee and or the Finance Performance and	Confirmed	The Trust audit opinion for the annual report and accounts 2016/17 states that the auditors were unable to satisfy themselves that the Trust has made the proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the financial year. This

		Business Development Committee.		was reflected of the deficit reported and that the Trust was required to apply for and receive distressed funding. The Board notes the opinion of the auditor however feels that the Trust has in place strong systems of financial and quality governance processes. NHS Improvement acknowledged following its investigation into the Trust that the Trust had already taken steps to address its financial challenges but that they had intervened to determine what additional support NHS Improvement could offer the trust as it seeks to reduce its predicted financial deficit and ensure its long term sustainability.
	(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	b) Performance review, service reporting arrangements, service review, performance dashboards at all levels within the organisation with systems for appropriate escalation and review to ensure timely and effective scrutiny and oversight of all operations.		
	(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	c) Effective systems and processes in place to ensure with national and local healthcare standards - internal and external assurance systems are in place and reported through the Trust's integrated governance framework.		
	(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	d) Financial and operational plans in place approved by the Board and discussed with Governors. Cost Improvement programme agreed with services and corporate departments. Contracts and business development managed appropriately. Workforce strategies developed to meet service demands, and workforce plans reviewed to minimise the use of agency/temporary staff. Robust procurement scrutiny to minimise costs and number of tender waivers. Annual and rigorous review of the Trust as a Going Concern overseen by Audit Committee and reported to Board.		
	(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-	e) Robust integrated governance structure in place. Board and committee structures fully serviced. Accurate, comprehensive, timely, up-to-		

	making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and NHS Improvement delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	date information available for Board and Board committees. f) Financial and operational risks identified in planning process and reported through the Board Assurance Framework/Corporate Risk Register. Oversight of the risks are provided through the integrated governance framework/structure and reported to the Board. g) Effective Strategic and business planning arrangements in place embedded within the trust and reviewed with Governors and CCG. h) Applicable legal requirements, against principal objectives and activities of the organisation reviewed and managed appropriately as part of the Trust's governance arrangements.		
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	a) Board capability reviewed against strategic direction and business plans. Focus on quality of care. Robust appraisal arrangements in place across the Trust. Medical Revalidation and appraisal systems in place and Leadership Management Development implemented across the Trust.	Confirmed	

	(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for	b) Quality of care fully integrated within all planning and decision-making processes. c) (and d) Performance and SEE reports, patient experience and quality of care initiatives routinely provided to Board Committees and reported to the Board by exception. d) Board receives a Patient Story every one/two months and receives presentations on quality of Care through its Board development workshops. Quality is prominent within each Board and Board Committee agenda. e) Board and Board Committees receive Patient Stories and presentations from staff on quality of care provided by the trust. Executive and NED ward and department visits to be undertaken to assess staff and patient care. Friends and Family Test systems in place and reported through the Governance Structure. Quality Strategy and Patient Experience Strategy in place and reviewed by GACA and Board. The Board through GACA receives reports on complaints (SEE Report). There is active engagement between the Board and the Council of Governors (CoG) - Board members attend all CoG meetings. f) Escalation of reporting embedded in the Trust. Systems in place to allow for escalation to the Board as required through the integrated		

	escalating and resolving quality issues including escalating them to the Board where appropriate.	governance structure.		
6	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Constitution sets out required numbers and qualifications for Board members. • Reviews undertaken by the Board and Governors Nominations Committee at time of recruitment of Executive and Non-Executive directors on the board mix, need and experience • The NEDs provide challenge and scrutiny through attendance a Board and Board Committees regarding appropriate staffing levels. • Through use of board assurance framework and risk management Strategy at Board, Board Committees and Sub Committees and Groups within the Trust Governance Structure • The financial and operational plan includes details on transformation and HR requirements including mitigation of risks associated with future workforce requirements.	Confirmed	

Other Statements:
The numbering in this document follows that provided in the NHS Improvement template.

2	Training of Governors	**Current arrangements**	**Response**

	The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	The Council of Governors are evaluated and training is provided during the year. Governors receive induction training and will have, as part of the induction, one to one sessions with the Trust Secretary at appointment. External training is provided through the NW Secretaries Group. Internal training is also provided at and during Council, Council Committee meetings and workshops to deal with specific areas of their roles and responsibilities. The Trust Secretary is available to respond to any matters that Governors may require clarification and if appropriate ad hoc training is provided should this be necessary. A programme of training necessary for Governors to undertake their role has been developed. Discussions with the Lead Governor and Governors continue on best forum to undertake training.	Confirmed

		Agenda Item	**2017/166(i)**
MEETING	Board of Directors		
PAPER/REPORT TITLE:	Board Assurance Framework		
DATE OF MEETING:	2 June 2017		
ACTION REQUIRED	**For Decision**		
EXECUTIVE DIRECTOR:	Doug Charlton, Director of Nursing and Midwifery		
AUTHOR(S):	Gregory Hope, Head of Governance		
LINK TO STRATEGIC OBJECTIVES:	All Choose an item. Choose an item. Choose an item.		
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Safe:*** *Choose an item.* ***Efficient:*** *Choose an item.* ***Experience:*** *Choose an item.*	***Effective:*** *Choose an item.* ***Well Led:*** Choose an item.	
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *Choose an item.* ***Caring:*** *Choose an item.* ***Responsive:*** *Choose an item.*	***Effective:*** *Choose an item.* ***Well Led:*** *5.2 Safe - Reg 17 Good Governance*	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)	Risk Management Strategy		
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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		
RECOMMENDATION: *(eg: The Board/Committee is asked to:-….)*	*1) Approve the closure of the 2016/17 Board Assurance Framework;* *2) Approve the Board Assurance Framework for 2017/18; and* *3) Agree that the proposals for future Board Assurance Framework papers to the Board will provide sufficient assurance.*		
PREVIOUSLY CONSIDERED BY:	**Committee name**	All Board Committees prior to presentation at Board	
	Agenda Ref.		

	Date of meeting	
	Summary of Outcome	Approved

1. Executive Summary

The Board agreed in March to oversee a project to refresh the Trust's Board Assurance Framework (BAF). Although there were significantly improved risk management arrangements over the last 2-3 years it was recognised that the Board had changed the BAF template over time with some key elements being lost. The agreed objectives of the project were to agree principles for the 2017/18 BAF, to consider changes in the process to further improve alignment with the corporate and operational risk registers and to identify the key strategic risks for inclusion on the BAF.

This paper details the work carried out as part of this project. It seeks to agree a BAF for 2017/18 and agree accompanying oversight procedures.

1. Issues for consideration

Closure of 2016/17 Board Assurance Framework

The first priority for the project was to assess the risks that were currently on the register. To ensure that all risks can be tracked through they have each been individually identified and assessed. The 2016/17 BAF risks detailed in Appendix 1 however the table below summarises the assessment and decision made in relation to each of them:-

Included in Proposed Risks for 2017/18	Included on corporate / operational risk register	No longer considered a risk
A, 1A, 1D, 1H, 1K, 1L, 1N, 3A, 4A, 4B, 4C, 5A, 5B, 5D, 5E	1B, 1C, 1F, 1G, 1J, 2A	1I, 1O,

Approval of 2017/18 Board Assurance Framework

The 2017/18 BAF risks approved by Executives and tabled today for final Board agreement are detailed in Appendix 2; they can be summarised as follows:

Strategic Objective	BAF Risk Descriptor	Executive Director	Operational Lead	Responsible Committee
Workforce	Engaged, motivated, effective, well-led workforce	Michelle Turner	Susan Westbury	PPF
Efficient	Long-term financial sustainability	Vanessa Harris	Jenny Hannon	FPBD
Efficient	Delivery of the annual financial plan	Vanessa Harris	Jenny Hannon	FPBD
Safe	Long-term clinical sustainability	Andrew Loughney	Devender Roberts	GACA

Safe	Learning from events	Andrew Loughney	Julie King	GACA
Safe	Regulatory compliance	Doug Charlton	Julie King	GACA
Effective	Best clinical outcomes	Doug Charlton	Devender Roberts	GACA
Experience	Positive patient experience	Doug Charlton	Julie King	GACA

Board Assurance Framework Reporting & Oversight Procedures

The main change in process for 2017/18 is that the Head of Governance will be assuming operational responsibility for the BAF. For 2017/18 this will include meeting with the Executive Director/s in advance of each sub-committee meeting to ensure correlation and ownership when presenting the paper.

Rather than reporting at each meeting the Board will received a quarterly BAF update in July, October, January and April. This will also be presented by the Head of Governance and will outline any proposals from sub-committees for change in risk rating or progress with actions and associated risks. It is expected they will also provide evidence for any proposed change. Also included in the quarterly paper will be detail from Corporate Risk Committee around challenge and additional actions regarding corporate risk ratings.

Risk Appetite statements have been prepared by each of the Board sub-committees against the strategic objectives for which they are responsible. These have been combined into an overall trust Risk Appetite statement which is also presented for approval here today. The appetite statement forms the basis of all future risk management and work towards target risk ratings.

A draft 2017/18 BAF was presented at a workshop of the Board in April. The objective of the workshop was to agree in principle to the reduction in the number of risks on the BAF and the increase in supporting corporate risks. Following this workshop each Executive Director has met individually with the Head of Governance and the external consultant appointed to assist in this project before tabling the final proposal that is here today.

Alignment of the Board Assurance Framework and risk registers

The Corporate Risk Committee will now have a role in reviewing the BAF and Corporate Risk Register together. This will allow greater challenge and inform the Board paper. The increase in the number of corporate risks will give greater breadth and support when discussing the BAF. They will also have a role in ensuring that operational leads are aware of the key strategic risks and how these link with the other risk registers.

Each Assurance Committee, in addition to making proposals to the Board, will provide feedback to Corporate Risk Committee and to subcommittees on the impact of operational risks, failure to manage in a timely way and any associated metrics that are not being met.

3. Conclusion

The Trust has commissioned a thorough project that has delivered a revised BAF that is fit for purpose and is approved and owned by Executive Directors.

The revised BAF provides 8 principal risks that, if appropriately managed, will allow the trust to achieving its strategic aims and objectives in line with its risk appetite. This includes achieving target risk ratings agreed by the Board.

The changes made will allow the BAF to be owned by the Board of Directors with Executive Directors being held to account for managing their risks. It will also now be a live document with clear alignment to the corporate and operational risks in the Trust. Actions against each of the risks will also address the causes of the risks, address gaps in controls & assurance and provide clear timescales by which Board and its sub-committees can challenge.

4. Recommendations

It is recommended that the Board of Directors:

a. Approve the closure of the 2016/17 Board Assurance Framework;
b. Approve the Board Assurance Framework for 2017/18; and
c. Agree that the proposals for future Board Assurance Framework papers to the Board will provide sufficient assurance.

5. Appendices

Appendix 1: 2016-17 BAF

Appendix 2: 2017-18 BAF

APPENDIX 1
2016/17 BAF

Appendix – Full details of 2016/17 BAF Risks

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

Risk Target / Risk Appetite - Significant

Risk Description	ID of Sub-Risks	Enablers	Exec Lead (Responsible Committee)	Risk Level		Key Controls/Mitigation Action	Assurance/Evidence	Gaps in Control/ Assurance Level?	Action	Date for Completion
				Initial	Current					
A) In order to be clinically and financially sustainable the Trust will need to undertake major change over an extended time period (five years). **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

Strategic Aim & Reference – 1: To deliver safe services

Risk Target / Risk Appetite - Low

Risk Description	ID of Sub-Risks	Enablers	Exec Lead (Responsible Committee)	Risk Level		Key Controls/Mitigation Action	Assurance/Evidence	Gaps in Control/ Assurance Level?	Action	Date for Completion
				Initial	Current					
1a) To ensure appropriate and safe staffing levels are maintained **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
1b) 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

1c) To consider and appropriately respond to NICE guidance**Risk:** Failure to comply may result in adverse public reaction, additional cost pressure or resources. Contractual obligation being compromised. **Cause:** Lack of robust, efficient and effective management system for decision Effect: Non-compliance or appropriate administration**Impact:** Contractual failure, loss of revenue or service, breaches of safety and adverse public reaction (complaint). **Ulysses Ref: 1733.**	1597	Quality StrategySafeguarding Strategy (draft)	MD (GACA)	**4X3 =12**	**4X3 =12**	• NICE guidance and clinical audit managed by Head of Dept.• Software generates compliance reports• Best Practice Policy• Reports to Clinical Governance Committee	•New External NICE Guidance (June, 2014), (Clinical Governance Committee, 13-06-2014, Item 14/15/83 ... 11-07-2014, Item 14/15/117 … 12 --09-2014, Item, 14/15/133)• Communication-LOTW	Yes	• Quarterly update to GACA-1. NICE guidance in last 1/4. 2. Compliance performance. 3. Non-Compliance rationale and risk.	December, 2016
1d) To ensure lessons are learnt shared, and appropriate change enacted from the reporting and investigation of incidents locally and across the wider NHS Community. **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
1f) To ensure the Trust has a robust business continuity plan that is understood and operational**Risk:** Failure to ensure the business continuity of the Trust **Cause:** Utilities, or Staff conditions creating major business interruption**Effect:** Limited service provision**Impact:** Compromised safety of service, financial loss. **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		

1g) 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	Yes	• Seek patient's and clinician's feedback on the handling of transfers	January, 2017
1h) 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
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

1j) 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		
1k) 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		

1l) 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

1n) Neonatal Estate**Risk:** Inability to safely meet the needs and demands of a changing neonatal service within the confines of the current environment and staffing establishment. **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: 1928**		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
1o) Junior Doctors Shortage on Neonatal Transport **Risk:** Inability to provide a Neonatal Transport service **Cause:** Shortage of junior doctors, skills gaps within junior doctor workforce **Effect:** Gaps in the Neonatal Transport Team rota, inability to provide a neonatal transport service **Impact**: Failure to transfer seriously ill patients, moderate to severe harm to patients. **Ulysses Ref: TBC**		Risk Management Strategy	ADOps (GACA)	**4x4 =16**	**4x4 =16**	• Training for ANNPs • Assessments of junior doctors against competency framework • Upskilling of existing ST4s • Collaboration on business plan to NHS England for North-West wide solution • Working with Manchester and NHS England on interim plan	• Letters of escalation to NHS England • Correspondence with Manchester • Training records for ANNPs and ST4s • Meetings with NHS England	Yes	Business case submission and decision from NHS England	March, 2017

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

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

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

Risk Target / Risk Appetite - Moderate

Risk Description	ID of Sub-Risks	Enablers	Exec Lead (Responsible Committee)	Risk Level		Key Controls/Mitigation Action	Assurance/Evidence	Gaps in Control/ Assurance Level?	Action	Date for Completion
				Initial	Current					
4a) A competent and capable workforce: To support workers to deliver safe care by ensuring that all staff are clear about their role, objectives and performance, and have the opportunity to have their competencies and knowledge regularly updated **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.**	1707 1704 1690 1445	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	

4b) An engaged, motivated and effective workforce: To deliver the Trust's vision of being a leading provider of healthcare to women, babies and their families through a highly engaged, motivated and effective workforce **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 employee**s** **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.**	1444 1445	Putting People First Strategy	DWM (PPF)	**4x4 =16**	**4x2= 8**	• Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff • 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	New leadership programme designed around the Trust values and behaviours framework Complete OLM project in accordance with agreed timescales Expedite roll out and promotion of e-learning Evaluate impact of pay progression policy. Develop project plan to implement Self Service	

4c) 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.**	146 1709 1635	Putting People First Strategy	DWM (PPF)	**4x3 =12**	**4x3= 12**	• Pro-formas sent to CD's to assess impact of industrial action on clinical activity and to make contingency arrangements. • 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 of Service have plans in place (SMT 6/1/16) Pro-forma re service provision 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	

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

Risk Target / Risk Appetite - Significant

Risk Description	ID of Sub-Risks	Enablers	Exec Lead (Responsible Committee)	Risk Level		Key Controls/Mitigation Action	Assurance/Evidence	Gaps in Control/ Assurance Level?	Action	Date for Completion
				Initial	Current					
5ai) To deliver the financial plan beyond 2016/17 **Risk:** The Trust does not have a financially sustainable plan in 2016/17 **Cause:** Tariff insufficiency, commissioner intentions, CNST premiums and liabilities and inability to identify further significant CIPs **Effect:** Requirement for Distressed Financing, Breach of Licence Conditions **Impact:** Regulatory Intervention **Ulysses Ref: 1663**	1663	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

5aii) To deliver the financial plan beyond 2016/17 **Risk:** The Trust does not deliver the 2016/17 financial plan and control total **Cause:** Lack of operational grip and financial controls **Effect: N**on-delivery of the financial plan and reduction in available cash **Impact:** Further regulatory intervention and special measures **Ulysses Ref: 1663**	1381	Risk Management Strategy	DOF (FPBD)	**5x3 =15**	**5x3 =15**	• Zero based budget methodology adopted • Voluntary turnaround process adopted to identify robust CIP schemes • FPBD & Board approval of budgets • Sign off of budgets by accountable officers • Monthly reporting to all budget holders with variance analysis • Monthly reporting to FPBD & Trust Board •Monthly reporting to Monitor	• 2016/17 plan approved by Trust Board in April • Performance & Finance Report presented monthly to FPBD • Finance & CIP achievement reported monthly to FPBD, Executive Team and Operational Board • Monthly budget holder meetings • Monthly reports to monitor • Internal audit review of budgetary controls	None	Ongoing review of position	Mar-17
5b) 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.**	1663	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
5d) 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 • Project Management Office • 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

5e) 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

APPENDIX 2
2017/18 BAF

Strategic Objective: To develop a well led, capable, motivated and entrepreneurial **workforce**

Risk Appetite: Moderate

Objective: To deliver a well-led, engaged, motivated and effective workforce

CQC Domain: Well-Led

Enabling Strategy: Putting People First Strategy

Executive Lead: Michelle Turner

Operational Lead: Susan Westbury

Assurance Committee: PPF

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 1744 **Condition:** Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust **Cause:** Poor staff morale, lack of clarity around objectives, lack of ability to influence in the workplace, lack of organisational/job security, insufficient numbers of staff with appropriate skill mix, age profile of key workforce groups, behaviour contrary to the trust values **Consequence:** Failure to deliver high quality, safe patient care, impact on recruitment & retention, failure to achieve strategic vision, potential for regulatory action and reputational damage	• Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff • Consultant revalidation process • Six monthly Safe Staffing Reviews • Annual Workforce Planning exercise • Retirement Intentions annual exercise • Pay progression linked to appraisal and mandatory training compliance. • Appraisal guides available for Managers and employees • Targeted intervention for areas identified as under-performing • Training programme for managers • All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities. • Extensive mandatory training programme available via classes, online resources and study days • Value-based recruitment & induction • Shared decision making with JLNC & Partnership Forum • Putting People First Strategy • Quality Strategy • Staff engagement programmes • Freedom to Speak Up Guardian • Whistleblowing Policy • Guardian of Safe Working • Reward and recognition processes	• Quality of appraisal • Poor attendance at non-mandatory training eg. leadership training • Managerial confidence to make decisions • Talent management programme is newly implemented and not yet fully embedded • Quality Strategy goals need to be refreshed and developed and owned by all staff • Difficulties and challenges of engaging effectively with all staffing groups	**Management assurance** • Executive Lead, Non-Executive Lead & Operational Lead assigned to Regulation 18 – Staffing (GACA - Sep'16, item 16/17/65) • Pay progression policy • Compliance with GMC & NMC Revalidation requirements (PPF - Sep'16, item 16/17/73) • Annual Staff Survey (PPF - Apr'17, item 17/18/xx) • Talent Management Programme (PPF - Jan'17, item 16/17/127) • Theatres Retention Programme (TTC – 28 Nov'16, item 16/17/70) **Metrics** • Increase in managers attending training programme • Mandatory training data • Absence data • Turnover data • Whistleblowing data • Staff Engagement Score • Sickness data	**Assurance Gaps** • Last CQC regulatory inspection was in 2015 • CQC Whistleblowing	• PPF deep dive into service workforce risks • Full implementation Self Service for managers and employees • Fully implement talent management programme • Work with Deloitte to complete a review of Executive working • Putting People First Strategy – in year objectives • Implement Quality Strategy objectives (experience domain)	• Ongoing • Nov-17 • Sep-17 • Nov-17 • Mar-18 • Mar-18
Risks from Risk Register • 1743 – Competent & capable workforce (Corporate Risk) • 1909 – Supply of junior doctors (Corporate Risk) • 1731 - Insufficient clinical staff to meet recommended staffing levels (Corporate Risk) • 146 - Inability to maintain safe medical rotas (Corporate Risk) • 1709 - Insufficient consultant or senior medical cover (Corporate Risk) • 9 x Service Risks			**Independent / semi-independent** • Review by Trust's internal auditors showed effective systems and processes (Audit – Jan '17, item 16/17/55) • CQC visit (Sep-15) identified improvement in appraisal rates and recorded compliance with 'supporting workers'.	**Outcome Gaps** • Staff Survey Engagement score not improved in year • Mandatory training currently below target • PDR compliance currently below target • Sickness absence above target		

Inherent risk level			Current risk level			Target risk position by 31.3.18		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	**25**	3	5	**15**	2	5	**10**

Strategic Objective: To be ambitious and **efficient** and make the best use of available resources

Risk Appetite: Moderate

Objective: Long-term financial sustainability

CQC Domain: Well-Led / Effective

Enabling Strategy: Strategic Options Appraisal

Executive Lead: Vanessa Harris

Operational Lead: Jenny Hannon

Assurance Committee: FPBD

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 1986 **Condition:** The Trust is not financially sustainable beyond the current financial year **Cause:** • Ongoing requirement for annual CIPs • Significant CNST premium • Overhead costs **Consequence:** Lack of financial stability, invocation of NHSI sanctions, special measures. Continued borrowing to meet operational expenses resulting in significant debt. **Risks from Risk Register** • 1749 – National re-commissioning of genetics (Corporate Risk) • 7 x Service Risks	• 5 year financial model produced giving early indication of issues • Business case to Trust Board which identified a solution which minimised deficit, including relocation to an acute site and merger • Early and continuing dialogue with NHS Improvement • Active engagement with CCG through the Healthy Liverpool Programme and Women and Neonatal Oversight Board, resulting in a Pre Consultation Business Case • Agreement for merger proposals with partner Trusts approved by three BoDs • Establishment of governance procedures to manage the merger transaction • Advisors with relevant experience (PWC) engaged early to review strategic options • Clinical engagement and support for proposals	• Implementation of business case is dependent on decision making external to the trust (CCG, NHSI, NHSE) • Uncertainty regarding availability of capital funding necessary to implement business case	**Management assurance** • 5 year plan approval (BoD – Nov 2014) • Future Generations Clinical Strategy and Business Plan (BoD Nov15) • Sustainability & Transformation Plan (FPBD – Jul' 16) • PCBC Approval (FPBD – Oct' 16) • Strategic Outline Case for merger approved by three Trust Boards (BoD Jun 16) **Metrics** • **Independent / semi-independent** • CCG Pre Consultation Business Case, approved by CCG Committees in Common	**Gaps** • **Outcomes** • Delivery of a surplus • NHS I use of resources rating above 2 over a five year time period	• Public consultation by CCG following development of preferred option • Further discussion with key stakeholders following outcome of consultation exercise • Decision making business case produced by CCG and final decision following outcome of public consultation • Business Case to support the application for capital to support the relocation • Merger transaction • Implementation of changes	• Sep-17 • Oct-17 • Dec-17 • Apr-18 • Apr-18 • Apr-18 to Apr 23

Inherent risk level			Current risk level			Target risk position by 31.3.18		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	5	5	25	5	5	25

Strategic Objective: To be ambitious and **efficient** and make the best use of available resources

Risk Appetite: Moderate

Objective: Deliver the annual financial plan

CQC Domain: Well-Led / Effective

Enabling Strategy: Operational Plan

Executive Lead: Vanessa Harris

Operational Lead: Jenny Hannon

Assurance Committee: FPBD

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - TBC **Condition:** Failure to deliver the annual financial plan **Cause:** • Slippage against CIP targets • Hewitt Fertility Centre loss of patient numbers resulting in reduced contribution • Increases in patient activity as contracts are largely on a block basis **Consequence:** Breach of license conditions resulting in financial special measures	• Robust budget setting process • Turnaround process adopted to identify robust CIP schemes • Quality Impact Assessments of all CIPs and post evaluation reviews • Sign off of budgets by accountable officers • FPBD & Board approval of budgets • Budget holder training programme in place • Monthly reporting to all budget holders with variance analysis • Monthly reporting to FPBD & Trust Board • Monthly reporting to and feedback from NHS I • Internal audit reviews of systems and controls	• None	**Management assurance** •2017/18 budget approval (BoD – Apr' 2017) •Budget holder training manual and attendance records •Performance & Finance Report (monthly to FPBD and BoD) •Finance & CIP achievement (monthly to FPBD) •Executive Team & Board oversight •	**Gaps** • Assurance is available re: controls but not on delivery	• Ongoing review of position	• April 18
Risks from Risk Register • 1663 – Operational grip on the creation and delivery of a financially sustainable plan (Corporate Risk)			**Metrics** •Monthly financial data **Independent / semi-independent** • Monthly reports to NHSI with feedback • Internal audit review of budgetary controls • External audit opinion	**Outcomes** • Delivery of £4m deficit in 17/18 • Delivery of £3,7m CIP for 2017/18 • NHS I Use of Resources Risk Rating – 3		

Inherent risk level			Current risk level			Target risk position by 31.3.18		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	**25**	4	5	**20**	2	5	**10**

Strategic Objective: To deliver **safe** services
Risk Appetite: LOW

Objective: Long-term clinical sustainability | **CQC Domain:** Safe | **Enabling Strategy:** Risk Management Strategy / Pre-Consultation Business Case

Executive Lead: Andrew Loughney | **Operational Lead:** Devender Roberts | **Assurance Committee:** GACA

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 1986 **Condition:** Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision. **Cause:** Deteriorating estate, off site ITU blood bank and diagnostic services, changing clinical standards, staffing levels, staff profile, changing demographics and co-morbidities, lack of co-located paediatric support **Consequence:** Patient harm, poor continuity of care, poor patient experience due to transfer away from booking location, the trust service offer is less attractive to commissioners	• Clinical engagement in case for change through Future Generations Strategy and PCBC • Advisors with relevant experience (PWC) engaged to review strategic options • Early and continuing dialogue with regulators • Active engagement with CCGs through the Healthy Liverpool Programme • Putting People First Strategy • Facilities Improvement Programme • Contract • Environmental risk assessments • Professional standards • Leadership & Management Development Programme • Acuity exercises • Clinical risk assessments	• Clinical case for change is dependent on decision making external to the trust (CCG, NHSI, NHSE) • Financial constraints for delivery of facilities improvements • Not all clinical staff have been/ can be engaged with • Lack of Staff Retention Policy • Capacity and access to Leadership & Management Development Programme • Non-inclusion of babies in acuity tools • No formal SLA for complex cancer patients	**Management assurance** •PCBC Approval (FPBD – Oct' 2016, item 16/17/90) •Operational Plan (FPBD – Apr' 2016, item 16/17/10) •Sustainability & Transformation Plan (FPBD – Jul' 2016, item 16/17/44) •Performance Report (from ward up through GACA and BoD) •Reports to NHS I (FPBD – Jul' 2016, item 16/17/48) •PCBC Oversight Board (BoD – Apr' 2017, item 17/18/xx) •Thematic review of SIs (GACA – Jul' 2017, item 17/18/xx) •Neonatal Update (GACA – Nov' 2016, item 16/17/xx)	**Gaps** • Most recent CQC inspection was 2 years ago and Safe domain required improvement • Gaps in fire provision	• Capital plan re: fire provision • Review the best model of care for complex cancer patients • Implement Operational Plan actions following NHS I approval • Agree a business case for a new build • Commence public consultation	• May-17 • Sep-17 • Mar-18 • Aug-17 • Sep-17
Risks from Risk Register • 12 x Corporate Risks (1597,1736, 1737, 1936, 1964, 2084, 2085, 2086, 2087, 2089, 2090, 2092) • 28 x Service Risks			**Metrics** •Performance monitoring of patient experience and clinical outcomes •Incident Data (including SIs / Never Events) •Safe staffing levels •Transfers out **Independent / semi-independent** • CQC Inspection (2015) • Review of fire provision • Vanguard review of Maternity Base • Neonatal ODM • Maternity SCN Dashboard	**Outcomes** • Failure to meet BAPM standards • Non-compliance of HBN accommodation standards on Neonatal Unit • Consultant presence on Delivery Suite • Transfers of complex cancer patients		

Inherent risk level			Current risk level			Target risk position by 31.3.18		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	**25**	4	5	**20**	4	4	**16**

Strategic Objective: To deliver **safe** services

Risk Appetite: Low

Objective: Learning from events | **CQC Domain:** Safe | **Enabling Strategy:** Risk Management Strategy

Executive Lead: Andrew Loughney | **Operational Lead:** Julie King | **Assurance Committee:** GACA

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 1742 **Condition:** Ineffective understanding and learning following significant events **Cause:** Failure to identify root cause, system structures and process, failure to analyse thematically, failure to respond proportionately **Consequence:** Patient harm, failure to learn and improve the quality of service and experience, poor quality services, loss of income and activity, reputational damage, increased staff turnover	• Regular dialogue with regulators and CCGs • Incident reporting and investigation policies and procedures. • MDT involvement in safety projects • HR policies in relation to issues relating to professional and personal responsibility. • Mandatory training in relation to safety and risk. • Staffing level acuity exercises • Scoping for relevant national reports • Quality Strategy • Risk Management Strategy • Governance structure • SI Feedback Form • SI Panels	• Inconsistent completion and dissemination of actions and improvement plans. • Limited evidence of Patient Safety walkarounds. • Inconsistent implementation of lessons learnt • Pace of implementing change • Lack of opportunity to deliver bespoke training for staff groups in relation to risk management and patient safety. • Quality Strategy is new and a 3 year programme for improving	**Management assurance** •CQPG (Apr' 2017) •CQC Engagement Meeting (Mar' 2017) •Performance Report (BoD – Apr' 2017, item 17/18/xx) •Mock Inspection Report (GACA – Jan' 2017, item 16/17/xx) •Never Events (BoD – Mar' 2017, item 16/17/xx)	**Gaps**	• Individual assessment of culture across the organisation (risk maturity). • Increase involvement with regional and local safety collaborative • Review local governance practice • Additional support and training for risk management • Introduce immediate challenge and action following serious incident declarations • Develop a never event assurance framework • Stakeholder engagement for quality improvement • Deliver the Executive visibility programme	• Sep-17 • Oct-17 • Sep-17 • May-17 • Apr-17 • Jun-17 • May-17 • Mar-18
Risks from Risk Register • 1734 – Repeat and costly patient safety incidents (Corporate Risk) • 1966 – Safety incidents during invasive procedures (Corporate Risk) • 2018 - Safe and effective Gynaecology Emergency Service (Corporate Risk) • 11 x Service Risks			**Metrics** • Safe domain performance metrics • Incident reporting • Levels of patient harm **Independent / semi-independent** • Internal audit of Risk Management (Oct-16) • External audit of risk maturity by Gorisa Ltd (Nov-16) • CQC Report (2015) • NRLS Incident Reporting Report	**Outcomes** • 4 x Never Events • Latest mock inspection assessed the trust as 'Requires Improvement' overall		

Inherent risk level			Current risk level			Target risk position by 31.3.18		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	**20**	3	4	**12**	2	3	**6**

Strategic Objective: To deliver **safe** services

Risk Appetite: Low

Objective: Regulatory compliance | **CQC Domain:** Safe / Well-Led | **Enabling Strategy:** Risk Management Strategy

Executive Lead: Doug Charlton | **Operational Lead:** Julie King | **Assurance Committee:** GACA

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 1739 **Condition:** Inability to achieve and maintain regulatory compliance, performance and assurance **Cause:** Lack of robust processes and management systems to provide evidence and assurance to regulatory agencies **Consequence:** Enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services	• Regular meetings with NHS Improvement • CQC engagement meetings • Maintenance of CQC registration • All Fundamental Standards allocated an Executive, Non-Executive and Operational lead; • Regulatory information provided to staff in update sessions. • Committee structures in place to monitor compliance. • Board assurance visits. • An integrated approach between corporate, operational and governance teams. • Quality Impact Assessments for all service changes and CIPs that are considered • Professional standards • Trust policies and procedures • Risk Management Strategy and culture • Corporate secretariat function • National audits • Local audits	• Benchmarking data can make the trust appear an outlier due to the specialist nature of the services provided and attract regulatory attention • Quality and independence of QIAs • Lack of a ward accreditation scheme	**Management assurance** • Statement of Purpose (GACA – xxx' 2016, item 16/17/xx) • Fundamental Standards Report (GACA – xxx' 2016, item 16/17/xx) • NHS Improvement monthly returns • Mock Inspection Report (GACA – Jan' 2017, item 16/17/xx)	**Gaps** • Regular internal monitoring of professional and regulatory standards	• Regular review of compliance position • Commence ward accreditation scheme • Maintain CQC rating of 'Good'	• May-17 • Mar-18 • Mar-18
Risks from Risk Register • 1836 – Inaccurate reporting of clinical outcome data. (Corporate Risk) • 1895 – Safeguarding of patients (Corporate Risk) • (Corporate Risk) • 8 x Service Risks			**Metrics** • Internal audit metrics • High level performance metrics **Independent / semi-independent** • Internal Audit Report (Mar-17) • CQC Inspection Report (2015)	**Outcomes** • 4 x Never Events • Latest mock inspection assessed the trust as 'Requires Improvement' overall		

Inherent risk level			Current risk level			Target risk position by 31.3.18		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	**20**	3	4	**12**	2	4	**8**

Strategic Objective: To participate in high quality research and to deliver the most **effective** outcomes

Risk Appetite: Moderate

Objective: Best clinical outcomes | **CQC Domain:** Effective | **Enabling Strategy:** Quality Strategy

Executive Lead: Doug Charlton | **Operational Lead:** Devender Roberts | **Assurance Committee:** GACA

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - TBC **Condition:** Inability to deliver the best clinical outcomes for patients **Cause:** Clinical capabilities and competence, recruitment and retention problems, trust location and estate **Consequence:** Increased patient safety incidents, increased levels of patient harm, loss of commissioner and patient confidence in provision of services, enforcement action, prosecution, financial penalties, reputational damage.	• Management of NICE guidance and clinical audit • Automated compliance reports • Regular programme of divisional reports to Safety and Effectiveness Senates • Training programme (mandatory and non-mandatory) • Clinical revalidation • Biannual internal inspection regime • Application of guidelines /policy led practice. • Governance processes around policies and guidelines • Clinical Audit Strategy including full involvement in relevant National Audit Programmes and reviews. • Mortality Strategy • All medical staff have work plans agreed with CDs and MD. • Analysis of patient feedback • Application of Patient Safety and other safety alerts. • Analysis of incidents, complaints and claims to identify areas of risk. • Case note reviews, morbidity and mortality reviews. • Supervision and education of clinical staff across all professions. • Application of clinical pathways and • guidelines. • Increasing R&D involvement across the organisation	• Clinical understanding of and use of overall and individual performance data • Inconsistent application of clinical pathways. • Appropriate support for clinical teams to be involved in clinical audit • Need to further enhance the shared learning across relevant directorates from audits • Availability of allocated time and people to undertake and provide clinical and educational supervision. • Quality Strategy outcomes monitoring not yet in place	**Management assurance** • Internal Audit Programme • Clinical Effectiveness audit programme • MDT approach to patient management • Directorate performance reviews • Case reviews and analysis • Research participation • Quarterly Mortality Reports • Annual Trust Mortality Report	**Gaps** • Difficult to gain consistent assurance that clinicians are following best practice • Some national audits / studies do not provide benchmarking of data, if they do this is in an inconsistent format making it difficult to accurately assess and compare trust status. • Lack of testing of action plans following audits to ensure they lead to embedded change.	• Introduce Adult Mortality Strategy • Introduce Perinatal Mortality Strategy • Introduce audit sheet for all adult deaths • Restate and rearticulate research vision with Liverpool Health Partners • Explore potential for direct research relationships with other local trusts • Improve data quality provision and oversight • Implement effective domain of the quality strategy	• Jun-17 • Jun-17 • Jul-17 • Jul-17 • Mar-18 • Jan-18 • Mar-18
Risks from Risk Register • 1733 – Failure to comply with NICE guidance (Corporate Risk) • 1738 – Failure to meet statutory and mandatory audit and CPD requirements (Corporate Risk) • 1740 – Failure to maintain policies & guidance (Corporate Risk) • 1741 – Failure to link research to strategic aim (Corporate Risk) • 1909 – Failure to maintain junior doctor numbers (Corporate Risk) • 14 x Service Risks			**Metrics** • Mortality metrics • Never events • Incident data • Quality Strategy metrics **Independent / semi-independent** • GMC / NMC Reports • Royal College Reports / Visits. • NCEPOD Reports • MBRRACE Reports • SHMI / RAMI • CQC Outlier Alerts • National Audits • Peer Reviews and accreditation. • R&D Performance and initiation data via DoH	**Outcomes** • MBRRACE outlier • SHMI outlier		

Inherent risk level			Current risk level			Target risk position by 31.3.18		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	**20**	3	4	**12**	2	3	**6**

Strategic Objective: To deliver the best possible **experience** for patients and staff

Risk Appetite: Low

Objective: A positive patient experience

CQC Domain: Experience

Enabling Strategy: Quality Strategy / Patient Experience Strategy

Executive Lead: Doug Charlton

Operational Lead: Julie King

Assurance Committee: GACA

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - TBC **Condition:** Poorly delivered positive experience for those engaging with our services **Cause:** Capacity and capability of staff, environment and estate, high turnover of staff, poor staff morale, non-acceptance of personal and professional responsibility, excessive waiting time, ineffective complaints/PALS system, poor food standard, poor staff attitude and behaviour **Consequence:** Failure to be the provider of choice, failure to achieve the strategic vision, loss of income and activity, reputational damage, regulatory intervention.	• Professional Codes of Conduct • Mandatory training and development for all staff groups. • Engagement with third party stakeholders, including Healthwatch and hard to reach groups • Complaints and compliments are reported and managed locally but with oversight by Board. • Application of policies, guidelines, procedures and strategies • Revalidation and clinical supervision • Trust values and objectives. • Attendance management policy • Appropriate skill mix across staff groups. • Peer support groups • Quality Strategy • Low level informal action and PALS • Patient engagement	• The Patient Experience Strategy is a 3 year strategy and is currently only in draft • Environment and estates issues require implementation of the PCBC • Confirmation of sustainability of changes and improvements is required • Consistent application of supporting staff policy • Consistent management of complaints and concerns across all areas • Consistent and accurate data regarding skill mix • Removal of statutory supervision with no agreed model in place • Limited patient engagement	**Management assurance** • Patient stories to Board (BoD – May' 2017, item 17/18/xx) • Staffing levels • Staffing red flags • Patient Opinion (BoD – Apr' 2017, item 17/18/xx) • Quality Report (BoD – May' 2017, item 17/18/xx) • PLACE Assessment	**Gaps**	• Consider how to enhance assurance levels around the involvement of hard to reach groups. • Introduce governor and volunteer exit surveys • Implement experience domain of the quality strategy • Appropriate use of acuity tools to ensure appropriate staffing levels • Respond to the findings of the CQC's national surveys (Maternity / Inpatient)	• Jun-17 • Oct-17 • Mar-18 • Nov-17 • Mar-18
Risks from Risk Register • 1863 – Breach of 18 week genetics targets (Corporate Risk) • 2088 – Inability to provide continuity of care (lack of co-location of all necessary support and clinical services) (Corporate Risk) • 13 x Service Risks			**Metrics** • Complaints data • PALS data • FFT Results • Staff survey engagement score • Vacancy / turnover levels • Safe staffing levels **Independent / semi-independent** • National Maternity Survey • National Inpatients Survey • Regulatory inspection	**Outcomes** • Staff survey engagement score – 3.77		

Inherent risk level			Current risk level			Target risk position by 31.3.18		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	**20**	3	4	**12**	2	4	**8**

Agenda Item	2017/166(ii)

MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	Risk Appetite Statement	
DATE OF MEETING:	2 June 2017	
ACTION REQUIRED	**For Decision**	
EXECUTIVE DIRECTOR:	Doug Charlton, Director of Nursing and Midwifery	
AUTHOR(S):	Gregory Hope, Head of Governance	
LINK TO STRATEGIC OBJECTIVES:	**All** Choose an item. Choose an item. Choose an item.	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***ALL*** ***Safe:*** *Choose an item.* ***Efficient:*** *Choose an item.* ***Experience:*** *Choose an item.*	***Effective:*** *Choose an item.* ***Well Led:*** Choose an item.
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *Choose an item.* ***Caring:*** *Choose an item.* ***Responsive:*** *Choose an item.*	***Effective:*** *Choose an item.* ***Well Led:*** *5.2 Safe - Reg 17 Good Governance*
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)		
FREEDOM OF INFORMATION STATUS (FOIA):	1. 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	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	1. Discuss, agree or amend the Risk Appetite Statement outlined in this report. ***2.*** Set the risk tolerance levels in relation to the trust's key strategic aims	
PREVIOUSLY CONSIDERED BY:	**Committee name**	The paper went to all Board committees to agree tolerance levels of risk prior to presenting at Board.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

1. Executive Summary

The Trust's Risk Management Strategy determines that on an annual basis the Trust will publish its risk appetite statement as a separate document. This paper asks the Board to discuss and agree a risk appetite statement setting out the Liverpool Women's NHS Foundation Trust's tolerance levels for risk in relation to the key strategic aims. The statement will define the Trust's appetite for risk to the achievement of strategic aims for the current financial year.

What is Risk Appetite?

Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to take on in pursuit of value. Or, in other words, the total impact of risk an organisation is prepared to accept in the pursuit of its strategic aims. Risk appetite therefore goes to the heart of how an organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, rating agencies and the public.

The amount of risk an organisation is willing to accept can vary from one organisation to another depending upon circumstances unique to each. Factors such as the external environment, people, business systems and policies will all influence an organisation's risk appetite.

What is the Process?

The Liverpool Women's Risk Management Strategy describes the process as follows:
"The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame". In practice, the Trust's risk appetite should address several dimensions:

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward.

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk. The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk"

Risk Appetite Levels

The following risk appetite levels, developed by the Good Governance Institute (see Appendix), form the background to discussion in relation to appetite. Using this model as guidance the Trust should agree an appetite statement that aligns to our strategic aims. The statement should be then be considered when assessing risk target and tolerances in the Board Assurance Framework

Appetite Level	Description:
None	**Avoid** : The avoidance of risk and uncertainty is a Key Organisational objective
Low	**Minimal** : The preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate	**Cautious** : The preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
High	**Open** : Being willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and value for money).
Significant	**Seek** : Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Also described as **Mature** : Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

2. Issues for consideration

It is proposed that the Risk Appetite Statement for 2017-18 is as follows.

To develop a well-led, capable and motivated **workforce**

Liverpool Women's NHS Foundation Trust operates in a complex environment in which it faces challenging financial conditions and changing demographics alongside intense political and regulatory scrutiny. However, the continued delivery of high quality healthcare services and service sustainability requires some moderate risk to be accepted where this is likely to result in better healthcare services for patients.

Support for moderate risk in service redesign that requires innovation, creativity, and clinical research to improve patient outcomes are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.

To be ambitious and efficient and make the best use of available resources

Liverpool Women's NHS Foundation Trust has a moderate appetite for risk to this objective. This is in respect to meeting our statutory financial duties of maintaining expenditure within the allocated resource limits and adherence to departmental and internal expenditure and financial controls. This includes the demonstration of value for money in our spending decisions.

To deliver safe services

Our risk appetite for safety is low. Our fundamental strategic aim describes our commitment to patient and staff safety. When and wherever possible we will apply strict safety protocols for all of clinical and non-clinical activity. We will not compromise the safety of our patients, we will report, record and investigate our incidents and we will ensure that we continue to learn lessons to improve the safety and quality of our services.

To participate in high quality research and to deliver the most effective outcomes

Liverpool Women's NHS Foundation Trust supports moderate risk against this objective. A level of service redesign to improve patient outcomes that requires innovation, creativity, and clinical research are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.

To deliver the best possible experience for patients and staff

Liverpool Women's NHS Foundation Trust has a low risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the Trust and its patients, may affect the experience of our patients, the reputation of the Trust or the reputation of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Senior Management Team.

3. Conclusion

Agreeing a Risk Appetite statement is a requirement of the Board under the Trust Risk Management Strategy. In order to treat, terminate, transfer, or tolerate risks staff undertaking risk assessments and making decisions will need to understand what level of risk is acceptable to the trust.

The Board's sub-committees, PPF, GACA and FPBD have met and agreed the parts of the statement for which they are operationally responsible. The Board are now asked to review the statement in its entirety and agree its publication.

4. Recommendation/s

The Board of Directors is asked to:

a) Receive the recommendations of its sub-committees regarding risk appetite and risk tolerance levels for 2017-18
b) Discuss, agree or amend the Risk Appetite Statement for 2017-18.

5. Appendix

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	