Meeting of the Board of Directors
HELD IN PUBLIC
Friday 1 September 2017 at Liverpool Women's Hospital at 1330
Board Room

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
	Thank you				1330 (10mins)	
234	Apologies for absence & Declarations of interest	Receive apologies	Verbal	Chair		-
235	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		Well Led
236	Speak Up Guardian Annual report	To receive feedback from the Speak up Guardian	Paper and Presentation	Chris McGhee - Speak Up Guardian	1340 (15mins)	Caring Responsive Well Led
237	Minutes of the previous meeting held on 7 July 2017	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1355 (5mins)	Well Led
238	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written/verbal	Chair		Well Led
239	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1400 (15mins)	Well Led
240	Chief Executive Report	Report key developments and announce items of significance not elsewhere	written	Chief Executive		Well Led

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
BOARD COMMITTEE ASSURANCE						
241	Chair's Report from the Finance Performance and Business Development Committee	Receive assurance and any escalated risks	Written	Committee Chair	1415 (15mins)	Well Led
242	Chairs Report from the Audit Committee	Receive assurance and any escalated risks	Written	Committee Chair		Well Led
243	Chairs Report from the Governance and Clinical Assurance Committee	Assurance regarding reporting and learning	Written	Committee Chair		Well Led
TO DEVELOP A WELL LED, CAPABLE AND MOTIVATED WORKFORCE; TO DELIVER SAFE SERVICES; TO DELIVER THE BEST POSSIBLE EXPERIENCE FOR OUR PATIENTS AND OUR STAFF						
244	Equality and Diversity Report and Presentation	Understanding the responsibilities of the Board	Written/Presentation	Cheryl Framer, Equity and Diversity	1430 (25mins)	Caring Well Led
245	Feedback from Listening event – July 2017	The Board is asked to note the content of the report	Written	Director of Workforce and Marketing	1455 (10mins)	Caring Well Led
246	Quarter 1 Mortality Report 2017/18	The Board is asked to note the content of the report	Written	Devender Roberts, Associate Medical Director	1505 (15mins)	Well Led
247	Safer Nurse/Midwife Staffing Monthly Report	The Board is asked to note the content of the report and be assured appropriate information is being provided to meet the national and local requirements.	Written	Director of Nursing and Midwifery	1520 (10mins)	Safe Well Led
248	(i) Health and Safety Annual Report 2016/17	To Receive the Health and Safety Annual Report following approval by GACA	Written	Director of Nursing and Midwifery	1530 (05mins)	Safe Well Led

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
	(ii) Quality Strategy 2017-2020	To approve the quality strategy 2017-2020 following amendment approved by GACA	Written	Medical Director		Safe Well Led
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES						
249	Performance Report period 4, 2017/18	Review the latest Trust performance report and receive assurance	Written	Director of Operations	1535 (10mins)	Safe Well Led
250	Finance Report period 4, 2017/18	To note the current status of the Trusts financial position	Written	Director of Finance	1545 (10mins)	Well Led
TRUST STRATEGY						
251	Fit for Future Generations Update	To brief the Board on progress and risks	Verbal	Chief Executive	1555 (5mins)	All
BOARD GOVERNANCE						
252	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1600	Well Led
HOUSEKEEPING						
253	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1615 End	Well Led

Date, time and place of next meeting Friday 6 October 2017

Meeting to end at 1615

1615-1630	Questions raised by members of the public observing the meeting on matters raised at the meeting.	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Meeting attendees' guidance, May 2013

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

Before the meeting

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

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

At the meeting

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

Attendance

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

After the meeting

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

Standards & Obligations

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

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

Page 129 Handbook to the NHS Constitution 26th March 2013

	Agenda Item	2017/236

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Freedom to Speak up Guardian – annual report**
DATE OF MEETING:	1st September 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Michelle Turner, Director of Workforce and Marketing
AUTHOR(S):	Christine McGhee, Freedom to Speak up Guardian
STRATEGIC OBJECTIVES:	***Which Objective(s)?***
	1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒
	2. To be ambitious and *efficient* and make the best use of available resource ☐
	3. To deliver *safe* services ☒
	4. To participate in high quality research and to deliver the most *effective* Outcomes ☐
	5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***
	1. *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒
	2. *The Trust is not financially sustainable beyond the current financial year* ☐
	3. *Failure to deliver the annual financial plan* ☐
	4. *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐
	5. *Ineffective understanding and learning following significant events* ☐
	6. *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐
	7. *Inability to deliver the best clinical outcomes for patients* ☒
	8. *Poorly delivered positive experience for those engaging with our services* ☐
CQC DOMAIN	***Which Domain?***
	SAFE- *People are protected from abuse and harm* ☒
	EFFECTIVE - *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐
	CARING - *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒
	RESPONSIVE – *the services meet people's needs.* ☒
	WELL-LED - *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒
	ALL DOMAINS ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution **2.** Operational Plan **3.** NHS Compliance	☐ ☐ ☒	**4.** NHS Constitution **5.** Equality and Diversity ***6.*** Other: **Click here to enter text.**	☐ ☐
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 contents of the report***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		**Putting People First Committee**	
	Date of meeting		23/06/2017	

Executive Summary

The role of Freedom to Speak up Guardian (F2SUG) is a mandated role. In October 2016 each NHS Trust in England was required to have in post a Freedom to Speak Up Guardian to support best practice in relation to raising concerns and to enable staff to speak up safely.

Freedom to Speak Up Guardians are charged with working with trust leadership teams to create a culture where staff are able to speak up in order to protect patient safety and empower workers.

The role of the National Guardian and Freedom to Speak Up Guardians have been created as a result of recommendations from Sir Robert Francis' Freedom to Speak Up review, published in February 2015.

Liverpool Women's Hospital (LWH) recruited to the role of F2SUG by an open recruitment and selection process in January 2016 with Christine McGhee being appointed into the role which commenced on 1st April 2016. In June 2016 the board received a presentation on the role of the Guardian.

The annual report explains how the role of the Speak up Guardian has been implemented and developed in LWH; the number and nature of contacts made to the Guardian (anonymised) over the past year; the response received from the Trust Managers in response to concerns raised; the governance surrounding the role; and the planned future development of the role.

The Board is asked to note;

1. The work of the Speak up Guardian at the Trust
2. The number , nature and responses given to concerns raised;
3. The Governance arrangements surrounding the role; and
4. The proposed future developments of the role

Liverpool Women's NHS Foundation Trust

Report

How the role of F2SUG has developed in LWH

Following the appointment and start of the role in April 2016, a work plan and implementation process was developed by the newly appointed Guardian this included:-

- Development of a Communications plan, which included meeting as many staff as possible by attendance at team meetings across the Trust, a poster campaign, an information stand in the conservatory, this work has continued albeit at a slower pace of late, information is on a dedicated intranet webpage, there are plans to improve this information and be accessible via social media which are ongoing.
- Trust induction – The F2SUG attends all Trust inductions both general and medical to meet new starters and introduce the role to new staff.
- Accessibility – the Guardian has dedicated contact methods, a dedicated mobile phone and in box, this is communicated to all staff via posters and cards which are handed out to staff regularly and to all new starters.
- Self-Assessment against national criteria- the F2SUG has completed with Head of Workforce a self-assessment against the Draw the Line Campaign and an action plan is in place. In August 2017 the F2SUG is currently undertaking a self-assessment against the National Guardians Competency framework.

Contacts by Staff

In the period December 2016 (last report to PPF) and end July 2017 a total of 11 contacts were made to the Guardian requesting support to raise a concern (see table below for breakdown) in addition to these another 6 contacts were made requesting a safe space to talk through a work related issue to identify if the staff member had a concern – these are usually issues related to Grievance or interpersonal issues within teams where no action is required by the Guardian.

The number of issues raised December 2016- July 2017	**11**	
The number of these issues raised anonymously	9	
The number of issues with an element of patient safety / quality	3	
The number of issues with an element of bullying / harassment	2	
The number of issues where people indicate that they are suffering detriment as a result of speaking up	1	
Contacts where a concern have not been raised but staff wanted to talk in confidence to work out how they could deal with an issue of concern to them only.	**6**	Examples would be :- • Trust Issues between staff and managers • Staff feeling manager hasn't responded as they wanted them to
People speaking up		
The number of issues raised by particular staff groups	0	Doctors
	2	Nurses
	1	Healthcare Assistants
	3	Midwives
	0	Dentists
	0	Allied Healthcare Professionals
	0	Administrative / clerical staff
	1	Cleaning / Catering / Maintenance / Ancillary staff

		4	Corporate service staff
		0	Board members
		0	Other
How Concerns were escalated by the Guardian			
Raised at	**Number**	**Response**	
Director Level	4	• 1 a full investigation was commissioned • Immediate action taken in 2 others, response to staff member within 2 day and ongoing feedback until resolution • HR intervention	
Senior Manager Level	**4**	• Recognition from line manager of the issue, positive response, investigation and feedback provided to person raising the concern	
Manager Level	**2**	• 1 occasion the line manager responded negatively initially but still provided an investigation and response • 2 Line managers expressed they felt they needed training in how to deal with the raising of the concern	
No action Required	**1**	No Action required as incident was historical	
Feedback from staff to Guardian after speaking up			
'Given your experience, would you speak up again?'			
The number of these that responded		10	Yes
		0	No
		1	Maybe
		0	Don't know
The top three most common themes to the feedback that you have received in response to the feedback question		• Thanks for your support / good to have support • Happy with actions and response and changes made as a result of raising my concerns • Trust took too long to investigate the concerns and get final responses/ outcomes	

F2SUG Learning from Feedback following the raising of concerns

As part of the development of the role of Guardian, it is important that the Guardian seeks feedback from staff about the support offered and the experience of raising a concern, below is a summary of the learning points for the Guardian following analysis of the feedback received.

Learning	
A summary of the main learning points over this period	Staff continue to feel anxious about raising concerns even though the feedback is positive from staff that have raised concerns – it is difficult in a small trust to do lessons learned as everyone knows everyone – I need to find a way of publishing the positive experiences without risking breaching confidentiality. Need to be clearer at the beginning of a concern raising episode that investigations can be complex and timely – longest one so far has been 10 weeks in

	total this was a complex staffing issue – staff member became frustrated, despite regular updates that investigations were ongoing. Listening to staff and being a safe space for them to talk through workplace dilemmas has been a theme this quarter, having space to talk to decide if they need to be concerned or to act is as important as helping someone to raise a concern. I need to re identify how I can dedicate protected time to the Guardian role, as my new role is very busy and I have gotten behind with the administrative and national updates.

National Guardian Network

The National Guardian Dr Henrietta Hughes was appointed in October 2016, she visited Liverpool Women's hospital on 31st October 2016, the first Trust visit nationally, she met with staff across the Trust and was pleased with how LWH had implemented the role of Guardian.

LWH guardian has spoken at national events with Sir Robert Francis to engage Non-Executive Directors in support of the Guardian role.

In March 2017 the National Guardian Conference was held and the LWH guardian attended, later this year there is another national event to continue to form a national network and benchmarking of standards for Guardians nationally, LWH Guardian continues to take an active role in the national development of the Guardian role with standardisation of reporting and feedback.

LWH is a member of the regional Guardian network; this group meets each quarter to develop a regional network of Guardians to provide support and guidance to individual Guardians.

The National Guardians office provides a monthly newsletter and weekly telephone clinic for Local Guardians to inform of developments and offer support.

The LWH Guardian reports quarterly to the National Guardians office the number and themes of all contacts to the Local Guardian; these contribute to a national reporting structure and inform the understanding of the culture of the NHS in relation to raising concerns.

Next Steps

There needs to be a continued effort to publicise the role with all staff to embed the role and to encourage staff to feel safe to raise concerns.

The Local Guardian will continue to work with the National Guardians Office and within the regional network to standardise the work of the Guardian and to share best practice and to learn from others.

- Continue to raise the profile of the role within the Trust working with Communication Team, Education teams and Managers to ensure staff have knowledge and trust in the role.
- Continue to work Nationally and Regionally with the National Guardian Network and National Guardians Office to ensure the LWH Guardian in working to best practice and work is standardised and recognised.

- Encourage raising of concerns in a variety of formats and methods, consideration needs to be given to development of electronic systems with will encourage staff to report concerns.
- Working with Governance and Safeguarding teams to review incidents and triangular against staff survey results and HR measures.
- Continue to improving information sharing and working relationships across the Trust
- Continue to develop the relationship of trust with medical staff and build links to publicise the role hoping to undertaken a joint meeting with medical staff with support from BMA regional representatives to inform Medical staff about raising concerns.
- Review the next Staff Survey results and target areas of low engagement and low staff survey results related to raising concerns in conjunction with HR.
- Development of the web page / single information site within the staff intranet as a single point of contact for staff with concerns to ensure it is easy to find and has all essential and useful information about raising a concern in LWH.
- Continued co-ordination with National Guardians Office developing the national reporting data set and supporting new guardians.
- Continue to develop and support the new Regional Network of Guardians across the North and establishing some common reporting measures and practices across the region.
- Continue to develop methods of gaining feedback from staff that have raised concerns to further improve the way the role of Guardian works within LWH.
- Refreshing the posters and information cards is needed to keep the message fresh
- Training for Managers in how to respond to staff when they raise a concern is needed, this has been developed but due to time constraints is not able to be rolled out to staff yet, and a pilot training session received excellent feedback from staff. This training is essential as part of improving the culture for staff within the NHS and was clearly identified by Sir Robert Francis in his report Raising Concerns.

Recommendation

The Board is asked to note;

1. The work of the Speak up Guardian at the Trust
2. The number , nature and responses given to concerns raised;
3. The Governance arrangements surrounding the role; and
4. The proposed future developments of the role

Board of Directors

Minutes of the meeting of the Board of Directors
held public on Friday 7 July 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
Mr David Astley	Non-Executive Director
Mrs Michelle Turner	Director of Workforce & Marketing
Dr Andrew Loughney	Medical Director
Mr Jeff Johnston	Director of Operations
Dr Doug Charlton	Director of Nursing & Midwifery
Mr Phil Huggon	Non-Executive Director

IN ATTENDANCE

Mr Colin Reid	Trust Secretary

APOLOGIES

Ms Jo Moore	Non-Executive Director

2017

Board Thank You

Jeff Johnston introduced Lesley Brown, Business Support Manager and Patient Services and thanked her on behalf of the Board. He advised that Lesley was a credit to the Trust and advised on all the hard work she had put into her role not only in the last few months but also since she started at the Trust.

181 **Apologies** – as above.

Declaration of Interests – None

182 **Meeting guidance notes**

The Board received the meeting attendees' guidance notes.

183 **Patient Story**

The Chair welcomed Kim Clarke, Genetics Counsellor to the Board to present a patient story from Genetics.

Kim Clarke advised that the outcome from a recent patient satisfaction survey revealed 100% of clinical genetics patients' were satisfied with their genetics appointment. She explained that as clinical genetics were the only department to achieve this, the Patient Experience team wanted to

understand what, as a service, Genetics were doing well and what could be shared across the Trust.

Kim Clarke introduced the short video of the Genetics patient who had contacted the Trust earlier this year, to thank the genetics team for her clinical genetics journey and offered to help the department in any way she could and agreed to provide a video of her story. Kim Clarke advised that story exemplifies the typical patient journey within clinical genetics department.

The Board received a video presentation of the patient's story. The story explained the family history which identified that the patient was at 50% risk of inheriting "c9orf74" gene mutation which predisposes to either early onset motor neuron disease and/or an inherited form of dementia.

The patient was referred into clinical genetics requesting a predictive test for the familial mutation. Over the following year a genetic counsellor met with the patient five times to discuss the possible impact the result could have on her psychosocially, emotionally, physically and financially. The concept of post decision regret, appropriate timing of receiving the result and how the result could be assimilated into her life was discussed, along with the underlying genetic cause, inheritance pattern of the condition, treatment and current research. Following careful consideration, deliberation and guided reflection undertaken in her genetic counselling appointment, the patient has decided not to proceed with a predictive test at this moment in time.

The patient wrote a thank you letter to the genetic counsellor following her experience with clinical genetics. She stated that she greatly appreciated the time and care that was taken to see her and to explore the complex and challenging issues around testing. She was grateful that the genetic counsellor persevered with her when arriving at her first appointment the patient "thought everything seemed to be clear" and "she just wanted the test". The patient went onto say how much she appreciated the genetic counsellors' willingness to engage with her intellectually and accessing recent research papers regarding the genetics of the condition.

The Board noted the outcomes from the patient story and the benefits the patients have from receiving counselling from within genetics when receiving the outcomes from the tests.

The Chair thanked Kim Clarke for presenting the patient story and the way the patient had been supported throughout her journey.

184 Hewitt Patient Story – update from the patient story received by the Board on 5 May 2017

The Director of Operations presented the update of actions that had been undertaken following the Fertility Patient Story received at the Board on 5 May 2017.

The Board noted the actions undertaken to address the concerns raised and requested that the Director of Operations update the Board at the October or November Board meeting that the actions had been closed.

185 Minutes of previous meeting held on Friday 2 June 2017

The minutes of the meeting held on 2 June 2017 were approved.

186 Matters arising and action log.

The Board noted that all actions were complete and were included on the agenda for the meeting.

187 Chair's Announcements

The Chair made the following announcements:

Council of Governors - Governor elections would be taking place during the summer for approximately a third of the elected governor constituencies. Announcement of the election results

would be done at the Annual Members Meeting due to take place on 14 October 2017.

The meetings of the Council's sub-groups have begun to take place which he felt would benefit the Council in discharging their role. All sub Groups would be supported by Non-Executive and Executive Directors and the meetings would allow for less formal conversational style discussions to occur.

5 Year Forward View (5YFV) - Andrew Gibson had been appointed as the Independent Chair of the Cheshire and Merseyside STP taking over from Neil Large. Louise Shephard was also stepping down as Executive lead of the STP and a replacement was being sought.

David Richmond - David Richmond undertook his last clinical session as a consultant at the Trust. The Board wished David well in his future endeavours.

NHS Providers – The NHS Providers Chairs and Chief Executives Quarterly meeting took place on 20 June 2017 and reported on the discussion that had taken place regarding the 5YFV, the Estates review and the discussion on the amount of backlog maintenance work and investment required on the NHS estates and the strategic and policy update (the links to the subject can be found within the Chief Executives Report). The Chair advised that the mantra from the DH was that there was still no additional money in the system.

The Board noted the Chair's verbal update.

188 Chief Executive's report

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

The chief Executive asked the Director of Operations to report on the Genetics and Colposcopy.

Genetics – The Director of Operations updated the Board on the developments with regard to the NHS England tender exercise for Genetics services. An engagement event had highlighted that the service specification would require less laboratories, 7 laboratories in the current tender process and in the future a further reduction to 4, in the country that would be high volume and technologically state of the art. The expectation is that current laboratories in geographical area's would come together in a collaboration to tender for the work. The Director of Operations advised that the Genetics team were already in discussions with Central Manchester on developing a partnership to submit a successful tender application in the autumn and advised that governance arrangements and confidentiality agreements were being developed to aid this work.

Ian Haythornthwaite asked whether there was a view on the future structure of the partnership. The Director of Operations advised that this was still being investigated to find the correct solution and structure. He went on to explain that a memorandum of understand was being drawn up that would set the tone of the future structure. The Chief Executive advised that with the reduced number of laboratories for the whole country it was important for the service that the Trust works very closely with Manchester to get the best possible outcome for the region.

The Director of Operations suggested that he bring to the Board at either the September or October Board meeting a papers explaining how the future of genetic services would look like from the Trust's perspective.

Colposcopy – The Director of Operations reported that the Trust's gynaecology colposcopy service had, due to long term sickness and other absences, suffered a loss of 75% (3staff) of its clinician workforce which had an associated impact on capacity. Business continuity plans had been implemented; however there was still significant pressure in terms of achieving diagnostic waiting times and referral to treatment targets. The Director of Operations advised that it was expected that

the business continuity plans would have a negative impact on income and expenditure in July due to the requirement to outsource some of the work and payment of waiting list initiatives. The Board recognised the risk to the service which was being mitigated.

The Board noted the Report from the Chief Executive.

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

Phil Huggon, Non-Executive Director and member of FPBD updated the Board on the work of the Committee at its meeting on 26 June 2017. Referring to the matter for escalation to the Board, Phil Huggon advised that a briefing paper has been included in the Board papers covering the performance target: 62 day cancer wait for first treatment from urgent GP referral for suspected cancer.

The Board noted the content of the FPBD Chair's Report.

190 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 23 June 2017. He reported that PPF was not quorate at the meeting due to the non-attendance of a staff side representative that was required as part of the quorum requirements. This non-attendance was being addressed and he hoped that such an occurrence would not happen again.

Referring to the matters discussed at the meeting, Tony Okotie advised that the committee had noted the increased pressures within corporate service areas when considering the Corporate Service Workforce Assurance Review. He reminded the Board that one of the main challenges faced by Corporate Services as a whole continued to be the way these services would be delivered in the future. The work being done around Future Generations and the region wide focus on shared services and streamlining would shape the future of these services which places pressures on retention. Tony Okotie reported on the good work within the Finance Team to keep the team motivated and engaged by ongoing support and regular team meetings in which 'Value Based Awards' were given out to staff. He explained that it was important that the Trust learn from what was being done in Finance so that there was not the potential loss of key staff in other areas as FG and focus on shared services begins to affect individuals.

Referring to the concerns regarding the shortage of junior doctors, Tony Okotie advised that the national shortage of junior doctors was becoming an increasing risk to the Trust which would create significant gaps in rotas. He explained that PPF needed to escalate this risk to the Board for its consideration. The Board considered the risk recognising that one of the factors impacting on attracting junior doctors to the Trust was the perceived uncertainty around the Trust's future and this required addressing urgently through the future generations communications plan. The Director of Nursing advised that the uncertainty surrounding the future of the services had also impacted on nursing and midwifery recruitment and it was therefore important to address the roles to move towards advanced practitioner roles. The Medical Director also drew the Board's attention to the trend of increasing difficulties in recruiting and retaining consultants and senior medical staff with the risks of managing complex patients on an isolated site being cited as reasons for leaving the Trust. The Board discussed and agreed that this was another important factor for having a timely resolution to the clinical need for change.

The Chair noting the concerns raised regarding attracting medical and nursing and midwifery staff felt that it was important to feed these issues into the Board workshop in August.

The Board noted the escalated risk discussed and approved the closure of the corporate risk 1909 relating the Supply of junior doctors in relation to industrial action.

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

191 Chair's Report from the Charitable Funds Committee (CFC) & Terms of Reference

Tony Okotie, Chair of CFC updated the Board on the work of the Committee at its meeting on 22 June 2017 referring in particular to the change of Chair of the Committee from himself to Phil Huggon. The Chair sought the Board approval of the change which was approved.

Tony Okotie ran through the main items discussed at the CFC and explained that the CFC would be reviewing its strategy with the Board following this meeting and would include focus on a potential fundraising campaign and the resources required to develop and support such a campaign.

The Board noted the activity of the CFC and approved the amendments to its terms of reference.

The Chair thanked Tony Okotie for his report and for his time as Chair of the Committee.

192 Serious Incident Report: Quarter 2

The Medical Director presented the Quarter 2 Serious Incident Report and explained that the report includes those he reported separately at the last Board meeting. The Medical Director reminded the Board that serious incidents were reported and reviewed internally at the Safety Senate and the Governance and Clinical Assurance Committee and that the report to the Board covers what was reported through those committees.

The Medical Director advised that the report includes serious incident reports completed during the last quarter in addition to recommendations made, lessons learnt and learning shared following root cause analyses. The paper provides an overview of the current status with respect to Serious Incidents in the Trust and seeks to provide sufficient information for the Board's assurance.

The Board discussed the incidents reported and recognised the changes that have been introduced to support more improved reporting and learning for dissemination across the Trust. Referring to potential for litigation arising from SIs the Medical Director advised that the improved reporting would allow for a better understanding of any potential litigation claim and quantum that may arise.

The Board noted the Serious Incidents Quarter 2 Report and confirmed that serious incidents were now being identified and managed in a timely and appropriate manner.

193 National Maternity Review – Update Report

The Director of Nursing and Midwifery presented his update report on the progress being made by the Trust on the redesign of the community midwifery services arising from the recommendations from Better Births: improving outcomes of maternity services in England (NHS England 2016), the report of the National Maternity Review.

The Director of Nursing and Midwifery explained that the Trust would be focused on specific areas: identification of hubs in suitable locations where services could be delivered from including ultrasound imaging, obstetric clinics, antenatal education and other support services such as smoking cessation and other public health message support; increasing the number of community births including homebirth and exploring freestanding birth centres; equitable access to an enhanced midwifery service providing support for vulnerable women experiencing complex health social factors such as perinatal mental health issues, substance misuse and child protection service input; consistency of breast-feeding support across the areas; offering contemporary antenatal education provision tailored to meet the needs of the women and families; examination of the New born provided in a timely manner in the most appropriate setting; provision of a model of continuity of carer within smaller teams promoting normality in pregnancy and birth whilst also coordinating care for women with additional risk factors; improvement in the Information Technology provision

available to community midwives and support workers; and reduction in the variation in the current service provision.

The Director of Nursing and Midwifery advised on the Trust's progress regarding the realigning and enhancing the community midwifery teams. He explained that the previous model of four teams had been reconfigured into three teams providing care across the three geographical areas of Liverpool, parts of Knowsley (Kirkby) and Sefton. This new configuration would go live in September 2017.

Referring to personalised maternity care budgets, the Board noted it had been asked to pilot the offering of care bundles to allow women the opportunity to make choices on what care they required within a notional budget. Concern was expressed regrading what would be required to be provided additional to a 'basic package' and if the Trust was required to provide a schedule of such additional services then there would be a potential impact on resources and a consequential impact on the financial wellbeing of the Trust. Ian Haythornthwaite felt that it was important before the pilot scheme was to go ahead, that the Trust was aware of what additional services would be required to be provided noting that it would be extremely difficult to predict what mothers to be would want.

Tony Okotie referring to the reduction in the number of community hubs felt that the Board should be made aware of any detrimental impact on patient experience and asked that the next update provides an update on whether this was the case.

The Board noted the current status of progress being made on the redesign of the community midwifery services and requested that a further update on progress is provided to the Board at its 1 December 2017 meeting.

Action 2017/196: The Director of Nursing and Midwifery to provide an update report on the implementation of the National Maternity Review to the 1 December 2017 Board meeting.

The Chair advised that Agenda item 2017/194 the report from the Director of Infection Prevention and Control would be taken after the agenda item 2017/199.

195 **Bi-Annual Nursing and Midwifery Staffing Report**

The Director of Nursing and Midwifery presented the Bi-Annual Nursing and Midwifery Staffing Report and advised that the Report had previously been presented and noted at the PPF Committee.

The Director of Nursing and Midwifery outlined the changes taken place in the last six months to assure that appropriate safe staffing levels were in place over the period and reported on the changes required on Mat Base to bring it back to an appropriate level of safe staffing and reported on the overall maternity Staffing ratio which stood at 1:30, which was within nationally accepted levels.
The Director of Nursing and Midwifery advised that neonatal staffing remains close to the nationally recognised BAPM standards and felt this was a good new story.

With regard to Ward Managers, the Director of Nursing and Midwifery went on to explain the proposed alteration to the supervisory status for Ward managers. He reported that ward managers would continue in their supervisory status, however to ensure there was greater visibility of ward managers on the Ward a change to the fulltime status of ward managers was being proposed with all ward managers retaining supernumerary status on three of their working days and the remaining two days would work on the Ward with staff to ensure senior nursing/midwifery presence on the floors.
The Director of Nursing and Midwifery advised that this provided an opportunity for the ward managers to fully appreciate the workloads and challenges staff face and provides time to work with individual members of staff and students to ensure direct observation of the quality of care delivered.
The Board noted the change being proposed and sought caution that Ward Managers may take their

eye off there supervisory/managerial role in particular the need to manage the staff under them and to undertake the important role of PDRs and make sure staff were doing the necessary mandatory training.

In response to a question on the incentive £50 payment per shift for additional Midwifery Bank, the Director of Nursing and Midwifery advised that this had been well received by staff.

The Board: received the report as assurance of safe nurse/midwife staffing levels for the period; noted the risk of the headroom allocation within workforce budgets; and noted the ongoing monitoring through the operational performance metrics and subsequent workforce reviews.

196 Safer Nurse/Midwife Staffing Monthly Report

The Director of Nursing and Midwifery presented the Safer Nurse/Midwife Staffing Monthly Report for May 2017 and reported that in future a monthly report would be presented to the Board to provide assurance on the management of safe nursing and midwifery staffing levels. He explained that the report would also provide context on the UNIFY safe staffing submission and provide assurance of the constant review of nursing and midwifery resource using Healthroster. The Director of Nursing and Midwifery advised that the Trust was required to submit monthly staffing levels both to the Board and NHS England.

Referring to the fill rate indicator the Director of Nursing and Midwifery explained the content of the table. Tony Okotie asked that if future reports are to be provided that they are sighted on the key messages that the Board needed to take from the tables. Ian Haythornthwaite also felt that the table did not give an indication on what the data meant to the Trust, whether the percentage above or below expected requirements. He further felt that in future trend analysis of the data could be shown.

The Chair in referring to the report welcomed the information provided but felt that there was no indication of what was a positive position and requested that the Director of Nursing and Midwifery review the report and provide additional information that would allow the Board to understand the relevance of the data provided.

The Board noted the content and recommendations contained in the report.

197 Performance Report Period 2 2017/18 & Cancer 62 Day – Rapid Recovery

The Director of Operations presented the Performance Report for period 2 2017/18 and reported on two measures that the Trust was not performing against target. He advised that the actual number of intensive care transfers out was provided over a cumulative rolling year as shown in the table and this equates to 15 patients against a target of 8. The other target relates to sickness absenteeism which shows an in month (May 2017) increase of 0.53% to 5.17% against a target of 4.5%. He explained that there had been an increase in sickness levels in all three of the largest clinical services and managers were working closely with HR teams to ensure that individual cases were managed appropriately, that staff were managed at the appropriate stages and that staff were supported in returning to work as soon as appropriate. Tony Okotie referring to sickness rates advised the Board that the PPF had been keeping sickness rates under constant review to address performance.

With regards to the target rate for "number of intensive care transfers out" the medical Director referred to previous discussions where he felt the target should be zero but due to being on an isolated site this could not happen.

Referring to the Cancer 62 day – Rapid Recovery paper, the Director of Operations advised that this indicator was no longer a NHS national measure but was deemed by the Board to be a good measure for the overall performance of cancer waiting times in partnership with other trusts. He explained

that it demonstrates compliance against the 62 day target no matter where the patient received treatment in the pathway. The Director of Operations reported that the Trust was compliant with cancer indicators, however nationally less than 50% of trusts were compliant. NHSI, in an attempt to improve overall cancer waiting times, had a plan to deliver a national recovery of the 62 day target by September and were supporting this with transformation monies. The Director of Operations provided an overview of the work to reduce the number of avoidable breaches and reported that the Trust was working with four other trusts in the region by improving patient flow and ensuring the right patients were referred appropriately.

The Board noted: the Performance Report for period 2 2017/18 report and the actions being taken to address the underperforming performance targets; and the actions being taken to address the 62 day cancer waiting times as set out in the Cancer 62 day – Rapid Recovery paper.

198 Financial Report & Dashboard Period 2 2017/18

The Director of Finance presented the Finance Report and financial dashboard for month 2, 2017/18 and reported that at Month 2 the Trust is slightly better than plan with an actual deficit of £0.581m against a plan of £0.595m and the Trust delivered a "Use of Resources" Rating of 3 in month which was equivalent to plan. The Director of Finance advised that in discussions with NHSI, they were happy with the current position.

The Director of Finance advised that she had concerns regarding the Trust's ability to deliver the full amount of CIP in year and the Executive was constantly reviewing the position, including reviews by FPBD. The Director of Finance advised that an in depth review of CIP would be undertaken at the end of quarter one and discussed at FPBD. The Chair asked that this included the 2018/19 initial planning work and that the outcome of the Q1 review and the prospects for 2018/19 be formally reported to the Board on 1 September.

Ian Knight asked that if CIP started to drag during the year, was there any mitigation that the Trust could do to support the financial position. In response the Director of Finance advised that there would have to be some serious consideration given to some not so palatable measures/decisions to be taken should this be required to deliver the control totals.

The Chair advised that a Board workshop had been arranged for the August board day to review a number of matters that required discussion which would include Quarter 1 CIP outturn.

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

199 Fit for Future Generations Update

The Chief Executive advised that there was nothing additional to add at this time.

194 Infection Prevention and Control Annual Report 2016/17

Dr Tim Neal, Director of Infection Prevention and Control (DIPC) joined the meeting to present the Trust's Infection Prevention and Control Annual Report 2016/17.

The DIPC provided a presentation on the areas of the report that he wished to draw the Boards attention to. He referred in particular to the work of the IPC team at the Trust, delivery against the work plan 2016/17 and the work plan for 2017/18.

The DIPC drew the Board attention to the successes in the Trust during the year including:

- The Trust reported no episodes of adult bacteraemia due to MRSA. Compliant with target
- The Trust reported no episodes of adult bacteraemia due to MSSA. Compliant with target
- The Trust reported no case of *C.difficile* infection Compliant with target
- The Trust has had no major outbreaks of infection in year.

- The IPCT has extended surveillance of SSI (perineal
- Increased Cannula & Pool audits
- Long standing HSSU environmental issue resolved
- Congenital infections being reviewed and involved external agencies

and the not so successful

- 1 amber rating on Health Care Act

The Chair thanked the DIPC for his presentation and felt it important to note that continuing to maintain standards and focus when there are no negative issues was important. The Chief Executive advised that the DIPC is aware that if he or his team does not get any traction on a particular matter that he escalates the matter to the Director of Nursing and Midwifery or herself to provide the necessary traction.

The Board discussed further the report which was approved. The Chair thanked the infection Prevention and Control team for their hard work, focus and diligence in dealing with the infection control across the Trust.

200 Review of risk impacts of items discussed

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

- Genetics and changes to future services
- Colposcopy – staff shortages, operational risks being addressed
- Junior Doctors Rotas – being addressed through PPF
- Learnings from Serious Incidents
- Maternity Care and the impacts of personalised maternity care budgets
- Performance against Indicators for intensive care transfers out, sickness absenteeism and activity in delivering 62 day cancer waiting time.
- Delivery of CIP and control total.

201 Any other business & Review of meeting

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. The Board felt that additional work was required when producing the papers in providing a good concise executive summary at the start of each paper.

Date and time of next meeting

The Chair reported that the next meeting of the Board in public would be 1 September 2017

Agenda Item 2017/238

Liverpool Women's NHS Foundation Trust

TRUST BOARD
September 2017 Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
7 July 2017	2017/196:	The Director of Nursing and Midwifery to provide an update report on the implementation of the National Maternity Review to the 1 December 2017 Board meeting.	Director of Nursing and Midwifery	On Target	

2017/239
Chairs Report - Verbal

Agenda Item	**2017/240**

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Chief Executive Report – September 2017**
DATE OF MEETING:	Friday, 01 September 2017
ACTION REQUIRED	**For Discussion**
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	Colin Reid, Trust Secretary

STRATEGIC OBJECTIVES:	***Which Objective(s)?***	
	1. To develop a well led, capable, motivated and entrepreneurial *workforce*	☒
	2. To be ambitious and *efficient* and make the best use of available resource	☒
	3. To deliver *safe* services	☒
	4. To participate in high quality research and to deliver the most *effective* Outcomes	☒
	5. To deliver the best possible *experience* for patients and staff	☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***	
	1. *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust*	☒
	2. *The Trust is not financially sustainable beyond the current financial year*	☒
	3. *Failure to deliver the annual financial plan*	☒
	4. *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision*	☒
	5. *Ineffective understanding and learning following significant events*	☒
	6. *Inability to achieve and maintain regulatory compliance, performance and assurance*	☒
	7. *Inability to deliver the best clinical outcomes for patients*	☒
	8. *Poorly delivered positive experience for those engaging with our services*	☒

CQC FUNDAMENTAL STANDARDS	***Which standard(s)?***			
	1. SAFE	☒	**4.** EFFECTIVE	☒
	2. CARING	☒	***5.*** WELL LED	☒
	3. RESPONSIVE	☒		
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution	☒	**4.** NHS Constitution	☒
	2. Operational Plan	☒	**5.** Equality and Diversity	☒
	3. NHS Compliance	☒	***6.*** Other: Click here to enter text.	

FREEDOM OF INFORMATION (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 content of the Chief Executive's Report – September 2017***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable Or type here if not on list: *Click here to enter text.*
	Date of meeting	*Click here to enter a date.*

Executive Summary

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.

Report

SECTION A - INTERNAL

Publication of CQC's 2016 Inpatient Survey: The CQC published national results for the 2016 Adult Inpatient Survey on 31 May 2017, which looked at the experiences of 77,850 respondents who were treated and cared for in hospital as an inpatient during July 2016. The survey asked patients for their views on aspects of their care, such as whether they felt they were treated with dignity and respect and whether they had confidence and trust in staff. The CQC have published a separate report which focuses on variation in results at trust-level and Liverpool Women's was identified as performing 'much better' than expected' compared to other trusts within the survey. The attached letter received from Professor Sir Mike Richards, Chief Inspector of Hospitals CQC provides additional details from the survey and links to the individual report. I would like to thank all staff for their continued dedication to delivering the best possible patient experience to patients attending the hospital.

Annual Members Meeting: The Annual Members meeting is to be held on 14 October 2017 from 10am in the Blair Bell. The event will include a complimentary breakfast, marketplace showcasing our services and staff and there will be some activities and entertainment for children. The Annual Members Meeting will highlight our recent achievements, our plans for the future and provide opportunity to patients, members of the Trust and the public to ask about things that matter to them.

Flu Vaccinations: The Trust will commence its flu vaccination campaign from 1st September when members of the Board of Directors will receive their vaccination just prior to the public Board meeting. The Communications Team will photograph the Board to support local promotion and awareness raising of the flu campaign to accompany all staff briefing messages to encourage uptake. In addition, as a repeat of last year the Trust will be working in partnership with other local Trusts (led by Liverpool Community Health) for a local-wide awareness and promotion campaign for both staff and members of the public – this will consist of joint promotional materials such as pull up banners, stickers, posters, and materials suitable for online circulation on website and social media.

Rotation of Junior Doctors: The following extract from Executive Team Minute of 27 July 2017 explains the discussion the Executive Team had surrounding the position with respect to the August rotation of Directors. The Executive Team agreed to increase both the inherent and current risk rating of Risk 146 with immediate effect, increasing the Inherent Risk to 20 (5x4) and the Current risk with existing mitigation in place to 15 (5x3).

> "The Committee received a paper outlining the position with respect to the August rotation of junior doctors. The Trust had several gaps on the rotas, particularly the Registrar rota, with the risk of this increasing during the year due to attrition and maternity leave. The Committee also noted the actions underway to mitigate the risk and the fact that PPF had commissioned a piece of work to identify the longer term plans to mitigate risk in the context of a shortage of junior doctors. In the meantime the committee agreed to increase both the inherent and current risk rating of Risk 146 with immediate effect, increasing the Inherent Risk to 20 (5x4) and the Current risk with existing mitigation in place to 15 (5x3)."

Butterfly Awards Shortlist: Congratulations to 3 members of staff who have been shortlisted for this year's Butterfly Awards. Sarah Martin and Marie Kelleher have been nominated for Bereavement Worker and Dr Umber Agarwal has been nominated for Health Professional – all 3 nominations have come from patients. The awards take place on Saturday 14th October 2017.

Health & Wellbeing Extravaganza: On Thursday 31st August 2017 there will be a Health and Wellbeing Extravaganza held at the Trust in the Blair Bell. Many different organisations will be there on the day promoting all types of health and wellbeing from mindfulness to physical activity.

Midwives on the Move: A group of our fantastic midwives will be walking 9 miles from Liverpool Pier Head to Otterspool Promenade and back on 16th September to raise money for the Liverpool Women's Charity! Please support them by making a donation on their Just Giving Page.

SECTION B – LOCAL

NHS Liverpool CCG: The Trust had recently been informed by Liverpool CCG of the resignation of Katherine Sheerin, Chief Officer of Liverpool CCG and Tom Jackson, Chief Finance Officer of Liverpool CCG and Lead Director for the Healthy Liverpool programme.

NHS Southport & Formby CCG: The Trust received notification from NHS Southport and Formby CCG that following their annual assurance assessment by NHS England, the CCG has been rated 'requires improvement' in the 2016-2017 results and an acknowledgment that progress had been made since being assessed as 'inadequate' in 2015-2016. The attached briefing has been provided which gives more detail about the CCG's assessment results and their next steps for the future.

Cheshire and Merseyside Sustainability and Transformation Partnership Lead: The Trust has been informed of the appointment of Mel Pickup, Chief Executive at Warrington and Halton Hospitals NHS Foundation Trust (WHH) and the new Cheshire and Merseyside Sustainability and Transformation Partnership Lead. Mel Pickup will retain her position at WHH whilst undertaking the new role on a part time 12 month secondment basis and will work closely with Andrew Gibson the newly appointed Executive chair.

Attachments:

- Publication of CQC's 2016 Inpatient Survey
- NHS Southport and Formby CCG - Annual CCG assurance assessment for 2016 - 2017

Publication of CQC's 2016 Inpatient Survey

14 July 2017

Dear Ms Thomson,

We published national results for the 2016 Adult Inpatient Survey on 31 May 2017, which looked at the experiences of 77,850 respondents who were treated and cared for in hospital as an inpatient during July 2016.

The survey asked patients for their views on aspects of their care, such as whether they felt they were treated with dignity and respect and whether they had confidence and trust in staff.

I am writing to you as we also intend to publish a separate report on 20 July which focuses on variation in results at trust-level. Your trust was identified as performing 'much better' than expected' compared to other trusts within the survey. This was because a higher proportion of patients responded positively about the care they had received.

The report will be available at the following link:
http://www.cqc.org.uk/publications/surveys/adult-inpatient-survey-2016

The statistical method used to identify positive patient experience focuses on the most positive response option a patient can select for any scored question. Patients at your trust gave the most positive answers to questions, across the whole survey, more frequently than the England average (68%).

We will continue to reflect your trust's performance on this survey within our Insight products as part of the information we have on how trusts are performing.

While I am sure you will want to share the results of this survey with your staff, the national level results in the Inpatient Survey statistical release, highlighted a substantial number of areas which declined between 2015 and 2016. This was particularly around patients feeling involved in their care, waiting for a bed on a ward, and care after leaving the hospital. We, therefore, also encourage you to look at your benchmark report, in order to identify any areas where you can continue to support further improvement.

We will shortly be advising NHS Improvement of the positive findings from your survey results by sharing a copy of this letter.

Yours sincerely

Professor Sir Mike Richards
Chief Inspector of Hospitals

NHS
Southport and Formby
Clinical Commissioning Group

Annual CCG assurance assessment for 2016 - 2017

NHS Southport and Formby Clinical Commissioning Group (CCG) has been assessed as ***'requires improvement'*** in the annual assurance process carried out by NHS England - an improved position on the previous year's result of 'inadequate'.

Overall, the assessment for NHS Southport and Formby CCG highlights both progress and ongoing challenges, whilst continuing to reflect the increasingly testing financial environment the organisation is operating in.

This briefing gives more details about the 2016-2017 results for the CCG and explains what the organisation is doing to improve its position, to ensure that local services are capable of meeting the changing needs of local residents and remain efficient and effective into the future.

Where the CCG is performing well

Whilst recognising there is more work to be done, the CCG has made good progress in moving from a rating of *inadequate* to *requires improvement,* reflecting the hard work carried out by the commissioner during a difficult year for the NHS.

Areas cited in the assessment as strengths or good practice include the following:

- The CCG's performance at or above the level required for the majority of NHS Constitution standards
- The CCG's openness in relation to its financial challenges is recognised, as is the strong oversight provided by the governing body and committee structure
- The CCG has a good control environment in place, with significant assurance received on all internal audits, including quality, stakeholder engagement and financial management, which will support the CCG in taking the difficult decisions that will be needed to address the continued financial challenge
- The CCG took a constructive approach to the planning and contracting round, and signed all its main contracts ahead of the 23 December 2016 deadline
- The strong leadership role taken to date by the CCG within the sustainability and transformation planning (STP) process, in particular the contribution of the accountable officer to local delivery system work

Where the CCG needs to do more

Some of the areas of continued challenge and development cited by NHS England can be seen below:

- The CCG's financial position remains the prime challenge for the commissioner and NHS England outlined its determination to support the CCG to deliver its 2017-2018 financial plan successfully
- Whilst NHS England recognised the good work carried out by the CCG across the wider urgent care system, it noted performance in this area remains to be a significant challenge. Efforts should continue with system partners to reduce delayed transfers of care and implement discharge to assess, trust assessor and primary care streaming initiatives
- Action should be taken with providers to improve cancer 62 day waits from urgent GP referral to first definitive treatment, along with access and recovery rates for Improving Access to Psychological Therapies, known as IAPT services
- Whilst the CCG's contribution to the STP is noted, NHS England states that there now needs to be increased focus on outputs and outcomes building on the Next Steps of the NHS Five Year Forward View

How does NHS England assess CCGs?

Each year, NHS England publishes the results of its ongoing assurance assessment of clinical commissioning groups (CCGs). This year it introduced a new and changed assessment framework. Called the improvement and assessment framework (IAF), it measures CCGs against 60 performance indicators selected to track and assess variation across 29 policy areas covering performance, delivery, outcomes, finance and leadership.

Much of the data assessed relates to the performance of the provider organisations, like hospitals and community services that CCGs commission services from. This includes the six clinical priority areas of cancer, mental health, dementia, maternity, diabetes and learning disabilities – updated results for the last three of these will not be reported until later in the year. NHS England also looks at the financial position of CCGs in addition to other information that also reflects the work of CCGs.

NHS England carries out its assessment in a number of different ways from scrutinising performance and financial data, to discussing progress in regular assurance meetings with CCGs.

You can find out more about the IAF process from the NHS England website.

The results of the CCG's assessment are published on the NHS England and My NHS websites.

Why has the CCG received this result?

Like all public sector organisations, NHS Southport and Formby CCG is operating in an increasingly demanding financial environment. The CCG also faces a number of distinct local challenges including:

- the increasing demand for healthcare
- the increasing cost of healthcare
- a significantly higher number of older[1], more frail residents who have more complex health needs

Whilst the CCG received 2% more money this year, the increase was much less than the national average of 2.14%. Coupled with increased local pressures and inflation rates, the CCG saw no real terms growth in its budget allocation.

What does the result mean?

NHS Southport and Formby CCG was placed in 'directions' following the 2015-2016 assessment and NHS England will be reviewing all directions to determine how these are updated to reflect the current position of CCGs.

The CCG will continue to implement the actions in its agreed improvement plan, focusing primarily on financial recovery, as well as securing improved performance around urgent care, IAPT access and recovery rates and 62 day cancer targets.

What has the CCG done so far?

NHS Southport and Formby CCG set itself a £12 million savings target for 2016-2017 and made good progress, delivering just under £7 million. Importantly, much of the work carried out by the CCG also helped to improve service quality for patients, as well as achieving efficiencies.

[1] Nearly 28% of the population over the age of 65 compared to around 18% nationally, with this expected to grow further over the next decade.

What more can the CCG do?

The CCG's savings target for 2017-2018 is £20 million.

NHS Southport and Formby CCG knows that current health services must change the way they operate if they are to continue to meet the needs of local residents in the future.

The CCG's 5 year strategy and Shaping Sefton programme focus on how core services can work better together, or 'join up', right across health and care so they are more effective and efficient in the future, in line with the NHS Five Year Forward View.

In addition, the CCG currently commissions a range of 'non statutory' or non core services that it is reviewing to ensure these also represent the best use of its NHS resources in achieving the best outcomes for local residents.

How are you involving local people in this work?

The CCG speaks regularly with local people through its Big Chat events and other involvement activities about their ideas for making health services more efficient and effective.

Involving patients, carers and residents in this work is vital, particularly where there are difficult decisions to make around health services.

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 24 July 2017

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

2. **Agenda items covered**
   - ~ Strategic Outline Case Update: The Committee received an update of the current status of the Trust's Strategic Outline Case, which summarises the financial and economic findings and the next steps. The Committee recommended that this report be considered in detail as part of private Board of Director discussions in August 2017.
   - ~ Month 3 2017/18 Performance Review: The Committee received Month 3 2017/18 performance dashboard. Since the Committee and Trust Board were informed about the increased focus to achieve the 62 day cancer target, the target was successfully achieved in Month 3. Work is continuing with the CCG with regard to agreeing the CQUIN's. The Committee noted performance against the FPBD indicators remains strong. The Committee were advised of an emerging risk in the Gynaecology nurse colposcopy service which is likely to impact on month 4 financial position.
   - ~ Month 3 2017/18 Finance Review: The Committee received month 3 2017/18 finance position and noted that at month 3 the Trust had performed slightly better than plan with an actual deficit of £0.353m against a deficit plan of £0.380m. Cumulatively the Trust is ahead of plan by £0.047m and is forecasting to deliver the full year control total. The monthly financial submission to NHSI is consistent with the contents of the report shared with the Committee.
   - ~ Cost Improvement Programme (CIP) Update: The Committee received a CIP tracker report at end of quarter 1 2017/18, noting a CIP shortfall against plan of £139k year to date, with £648k being delivered against a target of £787k. The largest risks to programme delivery were noted as the LCL Pathology Services, Inpatient redesign, Outpatient redesign and the MARS scheme. The four schemes combined make up 75% of the underachievement year to date. Two areas of emerging concerns to achieving CIP delivery were raised, which are the Community redesign project and Estates management. A further and final effort to resolve the position with LCL would be attempted. CIP mitigation is still under review.
   - ~ Corporate Services Benchmarking and Reference Costs: The Committee received a paper detailing the Trust's progress against recommendations made by Lord Carter of Coles, in his report Operational productivity and performance in English NHS Acute hospital. The Carter Review sets out that Trusts corporate and administration functions should rationalise to ensure their costs do not exceed 7% of their income by April 2018 and 6% of their income by 2020.The Committee noted the difficulties to achieve such savings, as a Specialist Foundation Trust. The Committee recommended that this report be considered in detail as part of private Board of Director discussions in August 2017.
   - ~ Hewitt Centre Update: The Committee noted strong income performance across Quarter 1 against the profiled plan. A potential risk to management controls was flagged to the Committees attention as the current interim managing director contract ends March 2018. The Committee supports the HFC Executive to develop a model of ownership and accountability.
   - ~ IM&T Update: The Committee received a verbal update noting no identified risks to programme delivery. The Digital Hospital Sub-Committee would take forward the EPR project and the GDE Fast Follower application, and report up to this Committee.
   - ~ Information Governance Update: The Committee noted achievement of level 2 – satisfactory against the Information Governance Toolkit. Proposed changes to data protection regulations were highlighted for the Committees attention.

NHS

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
   ~ Emerging risk in Gynaecology Nurse Colposcopy Service: The Nurse Colposcopy service has suffered from a loss of 75% of the work force (3 staff) and therefore associated capacity. Business continuity plans have been implemented but this adds significant pressure in terms of achieving diagnostic waiting times and referral to treatment targets. The continuity plans also impact on income and expenditure negatively due to outsourcing some work and paying waiting list initiative fees. This is expected to impact month 4 financials position. Every effort is being made to ensure that overall access targets continue to be achieved.

5. Issues to highlight to Board
   The Committee advised that the position with LCL had remained unchanged for a number of months. A final formal request by the Chief Executive would be issued to resolve matters. Further consideration of clinical risks would be identified by the Director of Operations before a recommendation to tender the service.

6. Action required by Board
   ~ None

Jo Moore
Chair of FPBD

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Audit Committee meeting held 24 July 2017

1. Was the quorate met? Yes

2. Agenda items covered

- Follow up of Internal Audit and External Audit Recommendations: The Committee received an updated position on implementation of outstanding recommendations from 2016/17. The Committee considered the process to track internal compliance and requested that the Executive Team review an updated report as close to the Committee meeting as possible to ensure the most accurate information is available. The Committee agreed to the closure of the Secondary Employment and Sickness Absence review as recommended by the Putting People First Committee.
- RSM Final 2016/17 Internal Audit Reports: The Committee received the final internal audit annual report, noting that the audit opinion remains unchanged from the draft annual report presented in May 2017.
- Internal Audit 2017/18 Work Plan and Progress Report: The Committee noted the update and approved the work plan for 2017/18. The Committee requested a position statement and timeframe for outstanding recommendations in relation to the Board Assurance Framework audit and the NPSA Alerts audit from the Director of Nursing and Midwifery.
- Counter Fraud 2017/18 Work Plan and Progress Report: The Committee noted the update and approved the proposed counter fraud work plan for 2017/18.
- Appointment of External Auditors Update: The Committee noted the process to be undertaken and approved the selection panel and timeframe to deliver the appointment process.
- Procurement Strategy Update: The Committee received an overview of the Procurement Strategy highlighting key work-streams.
- Register of Waivers: The Committee received the register of waivers for quarter 4 2016/17 and quarter 1 2017/18.
- Process for preparing and approving NHS Improvement (NHSI) returns: The Committee received an overview of the process undertaken to prepare and approve NHSI returns, noting the in –year monitoring return and self-certification confirmations.

3. Board Assurance Framework (BAF) risks reviewed

- Board Assurance Framework (BAF): The Committee received a paper describing the process taken to refresh and review the Trust's Board Assurance Framework. The Committee approved the process.

4. Escalation report to the Board on Audit Performance Measures

- None

5. Issues to highlight to Board

- None

6. Action required by Board

- None

Ian Knight
Chair of Audit Committee

NHS

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Governance and Clinical Assurance Committee meeting held 17 July 2017

1. Was the quorate met? Yes

2. Agenda items covered

~ Serious Incident Update Report: The Committee noted an increased focus to ensure SI actions are relevant and achievable and set within appropriate timescales. This is in response to emerging concerns relating to the number of SIs reported, as highlighted by Month 1 Performance indicator report.
~ Health and Safety Annual Report: The Committee received the Health and Safety Annual Report for 2016/17. It was noted that the Health and Safety Committee would be re-established chaired by the Director of Nursing& Midwifery reporting to the Safety Senate.
~ The Committee received a verbal update on fire safety as a result of an estate review in response to the Grenfell Tower fire incident. It was confirmed that the cladding on site is not a risk. A formal update would be presented to the Finance, Performance & Business Development Committee.
~ Litigation and Claims Update: The Committee received a retrospective review of the Verita independent review of governance report action plan, as remitted by the Board of Directors. The review confirmed maintained compliance with the recommendations. The Committee were informed that there are 12 remaining open cases relating to the urogynaecology group action claim which are anticipated to be settled by the end of September 2017.
~ GACA Performance Indicators Report: The Committee received Month 2 2017/18 performance dashboard. The Committee noted the addition of a new indicator 'reduction in medication errors' as an identified priority within the 2017-20 Quality Strategy.
~ Research and Development Annual Report 2016/17 and Forward Plan for 2017/18: The Committee received the Research and Development Annual report and Forward plan. The Medical Director would be presenting a Research Strategy to the next Committee.
~ Complaints Annual Report: The Committee received the Complaints Annual Report 2016/17.
~ National Inpatient Survey Results: The Committee received a report and action plan in response to the National Inpatient Survey conducted by the Picker Institute in 2016, noting that the Trust was ranked 6th overall in the Best Performing Trusts category out of 83 participating Trusts. This report would be presented to the Council of Governors in July 2017.
~ Amendment to the Quality Strategy 2017-2020: The Committee approved an amended final version of the Quality Strategy 2017-20, as requested by senior neonatal clinicians.

NHS

The Clinical Commissioners have been informed of the changes made and recognise the reasoning for the amendment. The Committee recommends Board approval.

3. Board Assurance Framework (BAF) risks reviewed

The Committee reviewed the BAF risks it was responsible for. No changes were considered and the scores remain appropriate.

4. Escalation report to the Board on GACA Performance Measures

None.

5. Issues to highlight to Board

~ The Committee would like to advise that a GACA review workshop is being arranged to consider the efficiency and purpose of the Committee as the Trust moves forward towards the Future Generations Clinical Strategy.

~ 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. A report is due back to Committee at its September meeting.

6. Action required by Board

~ Approval of the amended final version of the Quality Strategy 2017-20 – see agenda item 17/18/36 GACA minutes.

Susan Milner
Chair of GACA

Agenda Item	2017/245

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Listening Event – 1 July 2017**
DATE OF MEETING:	Friday, 01 September 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Michelle Turner, Director of Workforce and Marketing
AUTHOR(S):	Jean Annan, Head of Organisational Development
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☐ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☐ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☐ **3.** NHS Compliance ☐	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**
FREEDOM OF INFORMATION (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*** • Receive and consider the feedback from the first Listening Event • Endorse the approach and commit to further regular Listening Events with staff • Provide challenge into the organisation and gain assurance that the feedback from staff is being acted upon	
PREVIOUSLY CONSIDERED BY:	**Committee name**	***Choose an item.*** Or type here if not on list: ***Click here to enter text.***
	Date of meeting	***Click here to enter a date.***

Executive Summary

Liverpool Women's has had historically lower than average levels of staff engagement compared to other specialist hospitals. A focus on leadership, health & wellbeing of the workforce and communications, as set out in the Trust's People Strategy, has resulted in a year on year improvement in staff engagement over a period of five years. However, the 2016 Annual Staff Survey saw a reduction in overall staff engagement, mainly due to a reduction in staff motivation ie the extent to which they look forward to coming to work and are enthusiastic about and absorbed in their work. Whilst the overall trend continues to be improving and the challenging wider context in which we have seen the slight deterioration is recognised, it is important that there is no complacency and that the Trust responds positively to address the potential for any further deterioration.

Another consistent feature of the survey feedback is that the relationship between staff and senior leadership could be strengthened. In response, the Board has committed to an enhanced visibility programme and regular listening events with staff from across the organisation. The first listening event was a significant success with honest, positive and constructive feedback and a desire expressed for these to be regular events. Intrinsic to building trust and confidence in the process is ensuring that feedback and where appropriate, actions, are taken and then tested at the next event to ensure they are embedded and having the required impact.

The listening events and Board visibility programme are just two aspects of the wider range of activities in the organisation to build increased levels of staff confidence and engagement, the impact and effectiveness of which are monitored through the Putting People First Committee.

In broad terms, the feedback from the first Listening Event was

- Staff welcomed the time to speak freely away from the workplace with very senior leaders

- They enjoyed the opportunity to spend time with colleagues from other areas/disciplines
- They heard about and realised the demands on each other
- They wanted their PDRs to be more meaningful and helpful, with recognition for good work done
- They wanted to see more Senior Managers out and about in the workplace
- They wanted the values and behaviours of the Trust truly modelled by all at every level, and that action be taken where that wasn't the case – they talked about being kind to each other
- They wanted learning from incidents to be constructive, positive and widely shared, driving an 'Always Event' culture rather than a 'Never Event' culture
- Tackling the culture that perpetuates silo working

Board are asked to

- Receive and consider the feedback from the first Listening Event
- Endorse the approach and commit to further regular Listening Events with staff
- Provide challenge into the organisation and gain assurance that the feedback from staff is being acted upon

Report

1. Background

The link between staff engagement and patient experience and outcomes has been well researched and documented. Staff engagement is complicated and can be affected by many factors, which include uncertainty and frustration caused by lack of control. It is well known that although communication and involvement with the development of the Future Generations strategy has been effective, with staff demonstrating a good understanding of the clinical case for change, people remain concerned about their future. Additionally, the staff survey has indicated that staff does not often perceive that they have good access to senior managers or that their voice is known. The ramifications for failing to explore these issues with staff may lead to increased turnover with talented and experienced staff leaving, discretionary effort and engagement reducing and patient safety and experience becoming compromised.

2. Potential reasons for deterioration

According to the Staff Survey, levels of motivation were reported to be lower compared with the previous year. This leads to lower levels of energy and all work is more difficult. Although lack of what is considered a fair wage is often cited as demotivating, it has been shown consistently through social studies and more recent research into NHS staff that only a small number of staff leave an organisation due to poor pay. This includes clinical staff. The greatest reason for leaving is staffing levels and inability to do a good job or to influence what is happening in an organisation. This compound the problems for those who stay are less effective and less resilient in dealing with high levels of pressure. This is also manifested in increased sickness where stress is a contributing factor

Control or influence rate highly as contributing factors in motivation and those who feel unable to influence their work become disengaged and powerless victims of the system. This process reinforces itself and resultant lack of flexibility and creativity and reliance on others to accept responsibility. Senior managers across the organisation have struggled with getting staff to accept responsibility for their own areas of work. Further, under pressure, people tend to look inwards and protect their own work and areas, which leads to silo working and inefficiencies due to lack of shared resources.

NHS organisations are by their nature hierarchical and working practices and pressures normally compound this natural state so that it is unusual and requires planning and energy on a daily basis to maintain a two way dialogue throughout the organisation. People are also aware that once they get the attention and involvement of senior

members of staff, often insurmountable problems are removed and progress can be made. This causes much frustration among staff who have ideas about how situations can be ameliorated but have little or no influence to be able to realise them. It is easy to feel disempowered and feel unable to effect change or improve the situation. This is enervating and makes work more difficult. Among those who feel they can influence and effect change, they generally feel more empowered and have higher energy levels.

3. What we did and why

The Listening Event involved staff from all disciplines and levels in the organisation. The session focused on the organisational values (Care & Learn) and gave people the opportunity to talk to senior staff about what it feels like to work at Liverpool Women's and what could be even better, using an appreciative inquiry technique. Staff were encouraged to identify and own solutions that would make the Trust feel like a better place to work.

Outcomes.

The key messages were:

- Staff welcomed the time to speak freely away from the workplace with very senior leaders
- They enjoyed the opportunity to spend time with colleagues from other areas/disciplines
- They heard about and realised the demands on each other
- They wanted their PDRs to be more meaningful and helpful, with recognition for good work done
- They wanted to see more Senior Managers out and about in the workplace
- They wanted the values and behaviours of the Trust truly modelled by all at every level, and that action be taken where that wasn't the case – they talked about being kind to each other
- They wanted learning from incidents to be constructive, positive and widely shared, driving an 'Always Event' culture rather than a 'Never Event' culture
- Tackling the culture that perpetuates silo working

The event was received in a very positive way. Energy levels of staff were noticeably higher on leaving the event and it is encouraging that it is still being talked about in the organisation and an overwhelming desire for the events to continue to give more staff the opportunity to engage with each other and senior leadership in a positive environment.

Table of Actions

Key Messages	**Actions**
Staff welcomed the time to speak freely away from the workplace with very senior leaders	Continue to host Listening events over the next year (next event October 6th). Inform subsequent events' discussions by feedback from previous events. Develop confidence and familiarity for staff to be able to approach Senior Leaders in a more informal way
They enjoyed the opportunity to spend time with colleagues from other areas/disciplines	Use personal letters to managers to: • Remind managers that staff have requested more huddles • Remind managers that shadowing opportunities should be made available to staff where appropriate • Increase awareness of value of shadowing Promote and maintain a list of people who would like to meet up on an ad hoc basis to chat about their areas and work

They heard about and realised the demands on each other	Promote Systems Thinking workshop As above Promote Culture of Kindness
They wanted their PDRs to be more meaningful and helpful, with recognition for good work done	Promote PDR workshop and Webinar for both appraiser and appraisee. Encourage staff to take more responsibility for their own PDRs
They wanted to see more Senior Managers out and about in the workplace	Continue "Walk Arounds". Seeing senior leaders in the work areas will become the norm
They wanted the values and behaviours of the Trust truly modelled by all at every level, and that action be taken where that wasn't the case – they talked about being kind to each other	All staff should attend PDR workshops Attend workshops to increase understanding of each other and self and ability to challenge others in a respectful, non-confrontational manner (assertiveness, values, resilience, MBTI, constructive conversations) Use opportunities to remind all staff of their own ability to influence the culture – kindness, smiling, taking responsibility for each other
They wanted learning from incidents to be constructive, positive and widely shared, driving an 'Always Event' culture rather than a 'Never Event' culture	Skills for Human Factors training (November) to be cascaded to all staff members. Integrate learning into Skills and Drills workshops Integrate into Weekly Briefs sent out by local managers Workshops that promote behaviours to develop an open culture – "how to have a constructive conversation", "transactional analysis", "systems thinking" To discuss with Operations Managers and Communications the best forum for sharing information
Tackling the culture that perpetuates silo working	Remind managers that shadowing opportunities should be made available to staff where appropriate Increase awareness of value of shadowing colleagues, those in other areas and senior leaders Promote and maintain a list of people who would like to meet up on an ad hoc basis to chat about their areas and work

4. What next

The Leadership Programme is being modified in light of the feedback from staff and a new module focusing on Staff Engagement is being developed. The monthly Team Brief 'In the Loop' is going to include feedback on the actions taken in response to the issues raised by staff in the Listening Events but with an emphasis on the shared responsibility to improve life at work.

We have also committed to hosting three further World Café events over the coming year with the next one being on October 6th These sessions will be used to explore further some of the items from session 1 or to introduce new ideas. Input and attendance from the Board of Directors is seen as fundamental to the credibility of these

sessions. As part of the evaluation, feedback will be gathered relating to staff engagement before and after the event

5. Summary

There is a considerable potential to increase staff engagement and morale through continuing with the listening events and acting on feedback. Elements of staff engagement are made up of ability to influence change in an organisation and motivation. It was clear from discussions immediately following the event and from subsequent ad hoc conversations that people really enjoyed the chance to talk to each other and to senior staff in the Trust, or other staff were disappointed that they had not been able to attend. Staff have perceived this as an opportunity to have their voices heard and were beginning to identify ways in which they could address some of the issues themselves. There were a considerable number of practical suggestions particularly related to breaking down silos and barriers. The raised energy levels were evident. It is important to maintain the events and provide ongoing opportunity for staff to continue these conversations whilst at the same time ensuring credibility is protected by feeding back what has happened as a result of these discussions.

As a consequence of this work, it is anticipated that the trust will over time experience an improvement in all of the elements that make up staff engagement and especially that between staff and senior leaders as this was highlighted as an issue for staff in the Trust last year.

6. Recommendation

The Board is asked to:

- Receive and consider the feedback from the first Listening Event;
- Endorse the approach and commit to further regular Listening Events with staff; and
- Provide challenge into the organisation and gain assurance that the feedback from staff is being acted upon

Agenda Item	2017/246

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Quarterly Mortality Report: Quarter 1 of 2017-18**
DATE OF MEETING:	Friday, 08 September 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	G. Hope, Head of Governance
STRATEGIC OBJECTIVES:	**Which objective(s)?** **1.** To develop a well led, capable, motivated and entrepreneurial **workforce** ☐ **2.** To be ambitious and **efficient** and make the best use of available resource ☐ **3.** To deliver **safe** services ☒ **4.** To participate in high quality research and to deliver the most **effective** Outcomes ☒ **5.** To deliver the best possible **experience** for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	**Which condition(s)?** **1.** Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust ☐ **2.** The Trust is not financially sustainable beyond the current financial year ☐ **3.** Failure to deliver the annual financial plan ☐ **4.** Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ☐ **5.** Ineffective understanding and learning following significant events ☒ **6.** Inability to achieve and maintain regulatory compliance, performance and assurance ☒ **7.** Inability to deliver the best clinical outcomes for patients ☒ **8.** Poorly delivered positive experience for those engaging with our services ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution **2.** Operational Plan **3.** NHS Compliance	☐ ☒ ☐	**4.** NHS Constitution **5.** Equality and Diversity **6.** Other please state: **Click here to enter text.**	☐ ☐
FREEDOM OF INFORMATION (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:** a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board b. Confirm that the Board are confident there are effective governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at this trust			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Choose an item. Or type here if not on list: Click here to enter text.	
	Date of meeting		Click here to enter a date.	

Executive Summary

The Board have previously been informed that both the National Quality Board and the Care Quality Commission have made clear that trusts should be developing systems and processes to review and learn from the deaths of patients under their care. It is expected that the Board of Directors oversee this work and receive quarterly reports on progress.

This report details how the trust is meeting the requirements laid down externally and provides details of mortality within the Trust during Quarter 1 of 2017-18. It concludes that there is currently evidence available that adequate progress is being made and that mortality rates are within expected ranges. The report outlines the work taking place operationally and being overseen by Effectiveness Senate and GACA.

Report

1. Introduction and summary

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

This overview outlines the most recent trust figures and headline findings in regards to mortality. It provides details to the Board of their own accountabilities while setting out the responsibilities of the Governance and Clinical Assurance Committee and Effectiveness Senate to monitor progress regularly and escalate as required; this includes escalation of exceptions from any audit work related to the risk of adult mortality, stillbirth and neonatal death.

2. Issues for consideration

The Board of Directors at its meeting on 15 May 2017 received the Adult Mortality Strategy and Perinatal Mortality Strategy for approval. The Board felt that the strategies needed additional emphasis on the trust's ambitions and aspirations on reducing avoidable deaths. The Board was also advised that a number of amendments had been requested by clinicians particularly with regards to the Perinatal Mortality Strategy. It was therefore agreed by the Board at its meeting on 15 May 2017 that both strategies would be approved subject to further review by GACA at its meeting on 15 May 2017. This work took place at GACA and was reported back to the Board through the Chair's report.

In parallel with this internal work, when the National Quality Board launched its Learning From Deaths policy in March 2017 in response to the CQC's report 'Learning, candour and accountability', it was made clear that trusts should be developing their systems and processes relating to how to review and learn from the deaths of patients under their care. Supported by NHS Improvement, they laid down several key requirements including

- From April 2017, trusts must collect new quarterly information on deaths including: the total number of patient deaths; the number of deaths subject to case record review; the number investigated as SIs; an estimate of the number thought more likely than not to have been caused by problems in care; the main themes and trends emerging from review and investigation; and what the trust is doing to address those themes and trends in order to improve care
- By September 2017, trusts should publish an updated policy on how they respond to and learn from the deaths of patients in their care
- From Q3 2017 onwards they must publish information on deaths, reviews and investigations quarterly via an agenda item and paper to their public board meetings.
- From June 2018, trusts must publish an annual summary of this data in their quarterly accounts.

3. Key Themes

Gap analysis versus the requirements of the National Quality Board

Requirement	Progress
From April 2017, trusts must collect new quarterly information on deaths including: • the total number of patient deaths; • the number of deaths subject to case record review; • the number investigated as SIs; • an estimate of the number thought more likely than not to have been caused by problems in care; • the main themes and trends emerging from review and investigation; and • what the trust is doing to address those themes and trends in order to improve care	**Complete** – This information is collected and reported to divisional mortality and morbidity meetings and is overseen by the Effectiveness Senate as a standing agenda item
By September 2017, trusts should publish an updated policy on how they respond to and learn from the deaths of patients in their care	**Partially Complete** – The recently approved Adult Mortality Strategy and Perinatal Mortality Strategy set out the trust's approach to responding to and learning from the deaths of patients in our care. The key elements of these documents will form the Trust Mortality Policy that will be approved by Effectiveness Senate on 15 September.

From Q3 2017 onwards they must publish information on deaths, reviews and investigations quarterly via an agenda item and paper to their public board meetings.	**Complete** – This information is included as part of the Serious Incident Update Report which is scheduled quarterly on the Board's Business Cycle
From June 2018, trusts must publish an annual summary of this data in their quarterly accounts.	**Partially Complete** – Data is available and will be published in quarterly accounts from 2018-19 onwards as per the requirement.

Mortality themes in Quarter 1

Adult Gynaecological Deaths

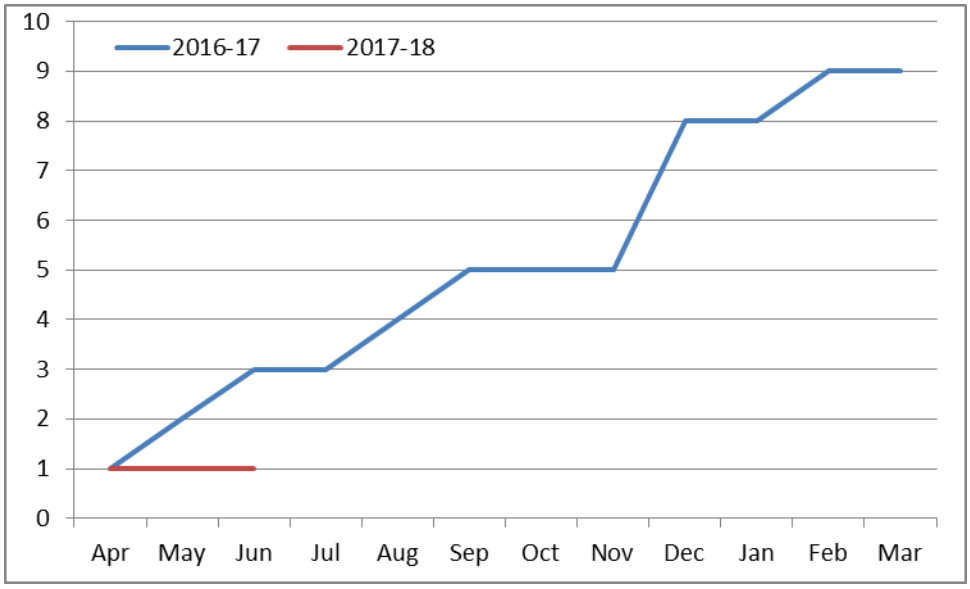


Figure 1: Cumulative Adult Gynaecology Deaths: Apr 2016-Jun 2017

- There was one adult gynaecology death in Quarter 1 of 2017-18. This compares to 3 in Quarter 1 of 2016-17.
- There were 12 adult gynaecology deaths in 2016-17, a reduction on the 14 in 2015-16
- The Quarter 1 death was assessed as an expected death.
- All adult gynaecology deaths are discussed at the gynaecology Morbidity & Mortality meeting. As part of this process an adult mortality sheet is completed indicating any potential for improvement in care. Unexpected adult gynaecology deaths trigger a serious incident investigation.
- The most recent serious incident investigation arising from a gynaecology death related to a death in August 2016. This patient was not an oncology patient. The investigation identified underlying co-morbidities not linked to the patient's treatment at Liverpool Women's.
- Benchmarking over the most recent period available (April 2016-June 2017) indicates Liverpool Women's is in the middle quartile of similar trusts, marginally below the mean mortality rate. If the current trajectory continues this position will further improve.

Stillbirths

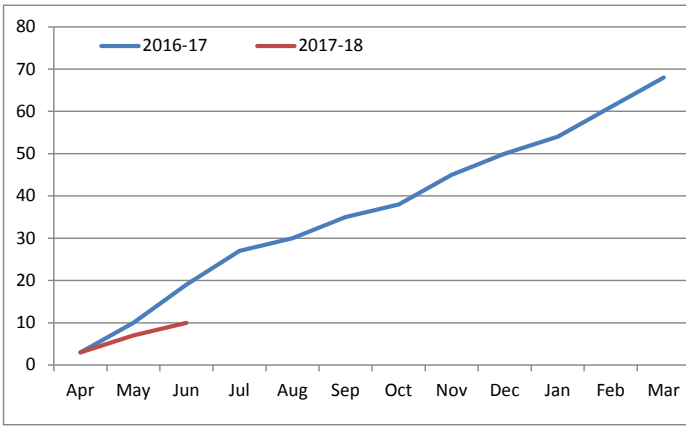


Figure 2: Cumulative Stillbirths: Apr 2016 - Jun 2017

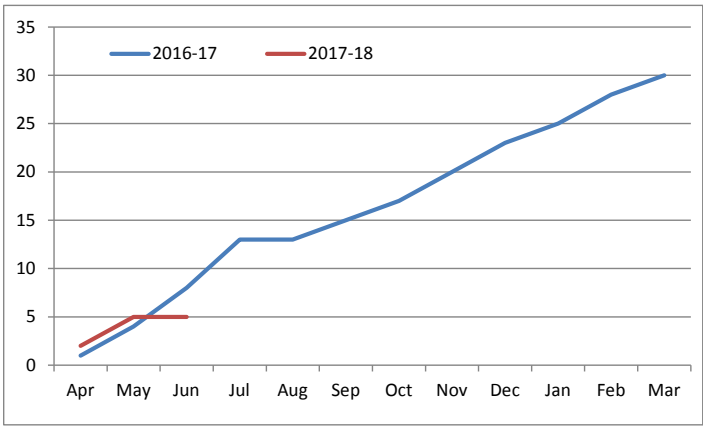


Figure 3: Cumulative Stillbirths (excluding terminations): Apr 2016 - Jun 2017

- Stillbirth can be defined as fetal death between the gestation of potential viability and the time of birth.
- There were 10 stillbirths at the trust in Quarter 1 of 2017-18. This compares to 19 in Quarter 1 of 2016-17. Included in these figures are late terminations. As a result it is more useful to consider the number of stillbirths excluding terminations when considering prevention and improvement.
- There were 5 non-termination stillbirths in Quarter 1 of 2017-18. This compares to 8 in Quarter 1 of 2016-17.
- There were 30 non-termination stillbirths in 2016-17, a significant reduction on the 43 recorded in 2015-16.
- All non-termination stillbirths are discussed at the trust Stillbirth Review meeting which includes external pathology and histology presentations. As part of this process all are given a CESDI grading indicating any potential for improvement in care.
- Any stillbirths meeting the criteria for Each Baby Counts are reported nationally and fully reviewed with external input
- All Intrapartum stillbirths trigger a serious incident investigation. The most recent serious incident investigations followed intrapartum stillbirths in Quarter 3 of 2016-17. This led to the commissioning of a review of the Maternity Assessment Unit led by Professor Alfirevic and a number of subsequent changes in practice. These included alterations to staffing mix and the introduction of traffic light triaging. Audits and monitoring of outcomes indicates these are proving a success thus far but will continue to be monitored closely.
- Benchmarking over the most recent period available (April 2016-June 2017) indicates Liverpool Women's is in the middle quartile of similar trusts, marginally above the mean mortality rate. The trust has previously been identified as an outlier and was firmly in the upper quartile until 2016-17.
- External benchmarking includes all stillbirths and there is no risk-adjusted methodology in place nationally for assessing stillbirth rates. This methodology is likely to overstate the risk at this trust due to its failure to take account of either terminations or case mix.

Neonatal Deaths

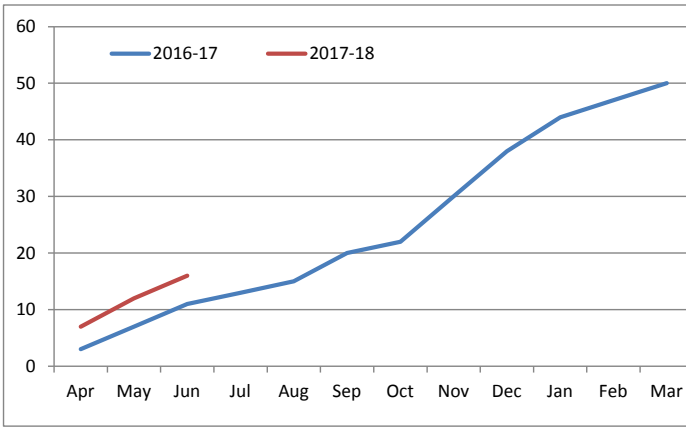


Figure 4: Cumulative Neonatal Deaths: Apr 2016 - Jun 2017

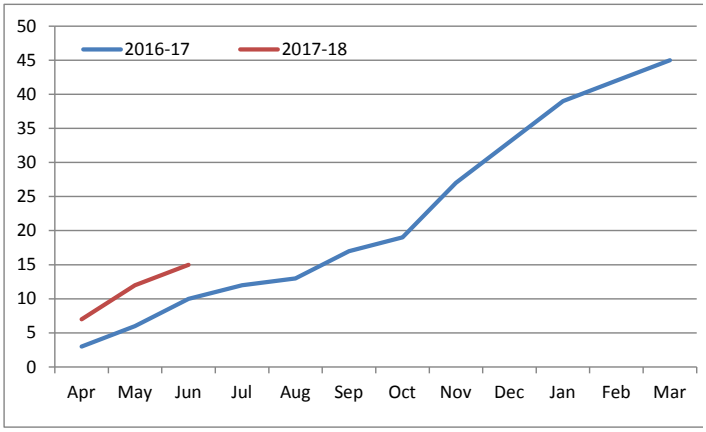


Figure 5: Cumulative Neonatal Deaths (excluding pre-viable neonatal deaths and terminations): Apr 2016 - Jun 2017

- Neonatal death is the death of a baby in the first 28 days of its life.
- There were 16 neonatal deaths at the trust in Quarter 1 of 2017-18. This compares to 11 in Quarter 1 of 2016-17. Included in these figures are pre-viable neonatal deaths and some terminations. As a result it is more useful to consider the number of neonatal deaths excluding pre-viable neonatal deaths and terminations when considering prevention and improvement.
- There were 15 neonatal deaths excluding pre-viable neonatal deaths and terminations in Quarter 1 of 2017-18. This compares to 10 in Quarter 1 of 2016-17.
- There were 45 neonatal deaths excluding pre-viable neonatal deaths and terminations in 2016-17, in line with the 44 recorded in 2015-16.
- Preterm birth is the single most important determinant of neonatal death, with over two thirds of all neonatal deaths occurring in babies born before 32 weeks gestation. The care of preterm babies at birth and in the early hours is an important determinant of survival. National recommendations are that a neonatal service providing the volume of intensive care that this trust does should have a consultant presence for 24 hours a day. The Trust's present commitment, contained in the Operational Plan, is to increase the consultant body by one new consultant per year over the next five years
- All neonatal deaths within the Trust are subject to multidisciplinary team review using a standard methodology. This allows the team to identify any deaths meeting the threshold for triggering a Sudden Unexplained Death in Infancy (SUDI) investigation, deaths requiring discussion with the Coroner and deaths necessitating a Serious Incident investigation. The intelligence produced by this approach has been used to inform service development priorities and drive service improvement.
- Any neonatal deaths meeting the criteria for Each Baby Counts are reported nationally and fully reviewed with external input
- Benchmarking over the most recent period available (January-December 2016) indicates that when only births booked at this trust are considered the Neonatal Mortality Rate at Liverpool Women's is below the national rate at 2.1 deaths per 1,000 live births. Many women are referred into this trust during their pregnancies because of concerns about fetal development or severe cardiac abnormality. Even when those babies transferred here for specialist treatment are considered the trust mortality rate is 0.4% above the national rate, within the Trust target of remaining within 1% of the national rate.
- The Vermont Oxford Neonatal network collects data that allow us to benchmark our very low birthweight and extreme preterm mortality against other neonatal units across UK and across the world, with risk adjustment for case mix. This provides reassurance that our mortality rates are currently within the expected range.

4. Conclusion

In conclusion the Board can take assurance that work to develop systems and processes to review and learn from the deaths of patients under their care is on track and has been implemented to a significant extent. There are plans in place to ensure full compliance within the necessary timeframes as set out by the National Quality Board.

Quarter 1 of 2017-18 saw reductions in adult gynaecology deaths and non-termination stillbirths. While there was an increase in neonatal deaths there is assurance available from all specialties that mortality rates remains within the expected range. There are detailed arrangements for the escalation and investigation of unexpected deaths across the trust and the strategies agreed at Board and GACA earlier in 2017 are beginning to become embedded.

5. Recommendations

It is recommended that the Board:

a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board

b. Confirm that the Board are confident there are effective governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at this trust

Agenda Item	2018/247

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**
DATE OF MEETING:	Friday, 01 September 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Doug Charlton, Director of Nursing and Midwifery
AUTHOR(S):	Doug Charlton, Director of Nursing and Midwifery
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL	**1.** Trust Constitution ☐ **4.** NHS Constitution ☐ **2.** Operational Plan ☐ **5.** Equality and Diversity ☐ **3.** NHS Compliance ☒ ***6.*** Other: **NHS England Compliance**

REQUIREMENT		
FREEDOM OF INFORMATION (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 content of the report and be assured appropriate information is being provided to meet the national and local requirements. • The organization has the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Director of Nursing & Midwifery	
PREVIOUSLY CONSIDERED BY:	**Committee name**	*Choose an item.* Or type here if not on list: *Click here to enter text.*
	Date of meeting	*Click here to enter a date.*

Executive Summary

Data presented demonstrates effective use of current Nursing & Midwifery resources for all inpatient clinical areas.

Overall fill rates versus planned remain high with the reallocation of nursing and midwifery resources where necessary to maintain safe staffing levels.

Four Red flags relating to staffing were reported during July. These reports related to Delivery Suite and the Gynaecology ward. These were due to shortages in planned staff from vacancies and short term sickness. This was managed appropriately using the redistribution of existing nursing and midwifery resources.

Nurse sensitive indicators are showing a continuous challenge with medication errors. All errors are investigated and appropriate action taken. No error resulted in harm to any patient. Three complaints were received this month two relating to Maternity and one to Gynaecology. There is a sustained reduction in the total number of written complaints received in the last few months due to the improvements made with complaints handling.

Overall Care hours per patient day remains at a sustained level indicating a consistent level of care delivery.

Bank staff usage remains at the set KPI of 6%, additional staff are used to fill gaps in rotas due to vacancies.

A recruitment drive in June saw the trust employ 24 additional midwives. It is anticipated there will be a reduction in the temporary bank usage during September and October as these new midwives become familiar with the trust policies and procedures.

Sickness levels remain above the set 3.5% KPI target at 4.5%. This is being actively managed by Matrons and Heads of Nursing /Midwifery

Staffing across the inpatient ward areas remains appropriate and safe to deliver patient care

Ward Staffing Levels – Nursing and Midwifery **Report**

1.0 Purpose

1.1 To provide the Trust Board with assurance with regard to the management of safe Nursing and Midwifery staffing levels for the month of July 2017.

1.2 To provide context for the Trust Board on the UNIFY safe staffing submission for the month of July 2017.

1.3 To provide assurance of the constant review of Nursing and Midwifery resource using Healthroster.

2.0 Context

2.1 The expectation is the Board 'take full responsibility for the care provided to patients and, as a key determinant of quality, take full and collective responsibility for Nursing/Midwifery care capacity and capability'.

2.2 Monthly nurse staffing updates are submitted to NHS England and the Trust Board with the following information:

1. The number of staff on duty the previous month compared to planned staffing levels.
2. The reasons for any gaps, highlighting those wards where this is a consistent feature and impacts on the quality of care, to include actions being taken to address issues.
3. The impact on key quality and safety measures.

3.0 Background

3.1 Liverpool Women's NHS Foundation Trust is committed to ensuring that levels of nursing staff, which include Registered Nurses (RNs), Registered Midwives (RMs) and Health Care Assistants (HCAs), match the acuity and dependency needs of patients within clinical ward areas in the hospital. This includes an appropriate level of skill mix of nursing and midwifery staff to provide safe and effective care.

3.2 Staffing levels are viewed alongside reported outcome measures, patient acuity (Delivery Suite), and 'Registered Nurse/Midwife to patient ratios', percentage skill mix, and the number of staff per shift required providing safe and effective patient care.

3.3 Care Hours per Patient Day (CHPPD) is an additional parameter introduced by the regulator NHSI to manage the safe level of care provided to all inpatients. This measure uses patient count on each ward at midnight (23.59hrs). CHPPD is calculated using the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight (for April data by ward please see Appendix 1).

3.4 Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 31st July 2017 for Liverpool Women's NHS Foundation Trust was uploaded and submitted on UNIFY, the online collection system used for collating, sharing and reporting NHS and social care data. Patients and the public are able to see how hospitals are performing on this indicator on the NHS Choices website.

3.4 Summary of Staffing Parameters

Standard	Patient Safety is delivered through consistent, appropriate staffing levels for the service - July 2017					
Ward	RN/RM		Non Registered			
	Fill Rate Day%	Fill Rate Night %	Fill Rate Day%	Fill Rate Night %	Total Workforce CHHPD	Red Flags
Delivery & Induction Suite	85.8	91.4	132.3	82.8	33.1	4
Mat base	85.9	80.2	76.1	84.4	6.0	0
MLU & Jeffcoate	87.6	81.7	87.1	93.5	42.0	0
NICU	111.9	112.3	87.1	41.9	12.6	0
Gynae Ward	101.9	96.7	89.7	96.8	9.9	1

Nurse Sensitive Indicators - July 2017								
Ward	**CDT**	**MRSA**	**Falls No Harm (N)**	**Falls Harm (N)**	**HAPU grade 1&2**	**HAPU grade 3&4**	**Drug Admin error**	**New Complaint**
Delivery & Induction Suite	0	0	0	0	0	0	0	2
Mat base	0	0	0	0	0	0	4	1
MLU & Jeffcoate	0	0	0	0	0	0	1	0
NICU	0	0	0	0	0	0	12	0
Gynae Ward	0	0	0	1	0	0	0	0

4.0 Fill rate indicator return

4.1 The 'actual' number of staffing hours planned is taken directly from our Nurse/Midwife roster system (Allocate). On occasions when there is a deficit in 'planned' hours versus 'actual' hours, and additional staff are required, staff are reallocated to ensure safe staffing levels across the clinical service.

4.2 Appendix 1 details a summary of fill rates 'actual' versus 'planned'. The average fill rate was 95.9 %for registered staff and 90.2 % for care staff during the day and 96.0 % for registered staff and 79.3 % for care staff during the night.

4.3 On the day and night shifts, three clinical areas reported staffing below 90% fill rates for qualified Nurses/Midwives. Two clinical areas reported above 100% fill rate for Registered Staff (Neonatal &

Gynaecology) on day shift. Induction & Delivery Suite reported above 100% for non-registered staff on day shift.

Day		Night	
Average fill rate registered Nurses /Midwives	Average fill rate Care Staff	Average fill rate registered Nurses/Midwives	Average fill rate Care Staff
95.9	90.2	96.0	79.3

5.0 'Real Time' management of staffing levels to mitigate risk

5.1 Safe staffing levels are reviewed and managed three times daily. At the daily 09.00am huddle meeting, the Director of Nursing or Deputy Director of Nursing in conjunction with Heads of Nursing/ Midwifery, Matrons, and other senior staff review all registered and unregistered workforce numbers by service. Consideration is given to bed capacity, patient acuity and operational activity within the hospital which may impact on safe staffing. Actions are agreed to ensure all areas are made safe. Matrons and Heads of Nursing/Midwifery review staffing levels again at 13.00 and 17.00 or at other times as decided appropriate to ensure levels remain safe.

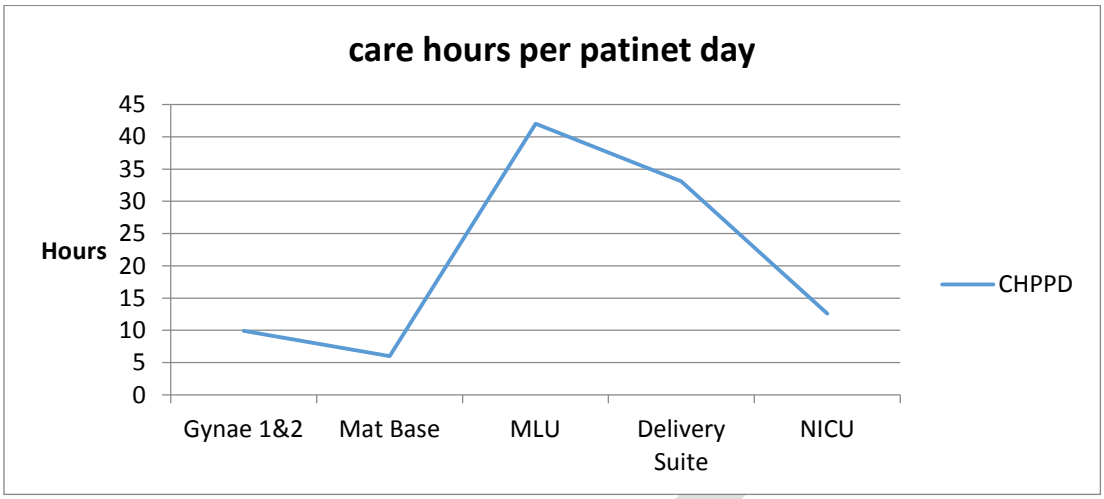
6.0 Reported Incidents of Reduced Staffing (Ulysses Reports)

	Initial Red Shifts				
Wards	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a red rating
Delivery Suite	1	1	2	0	4
Gynae 1 & 2	1	0	0	0	1

6.1 Staff are encouraged to report any incident they believe may affect safe patient care using the Ulysses system. During July four reports was submitted relating to the Delivery Suite. A review of the staffing was undertaken by the Matron and a decision made to reallocate Midwives from other clinical areas to ensure the clinical floor was safe. The reduced staffing on the Gynaecology ward was supported by staff from other areas of the Gynaecology service to ensure all patients received appropriate nursing care.

7.0 Care Hours per Patient Day (CHPPD)

7.1 Care hours per patient day is calculated using the patient count on each ward at midnight (23.59hrs). CHPPD is calculated taking the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight. The graph below shows the average individual care hours per patient for each clinical area. MLU have the most care hours (42.0 hours) and the Maternity Base have the least (6.0 hours). This is in keeping with the average amount of care delivery required in these two clinical areas.



7.2 The average number of hours of Registered Nurse/Midwife time spent with patients was calculated at 10.6 hours and 2.5 hours for care staff. This provides an overall average of 13.1 hours of care per patient day.

	CHPPD
Registered Nurse/Midwife	10.6
Care Staff	2.5
Overall hours	13.1

7.3 The total care hours per patient day is one of the metrics used on a daily basis by the Senior Nursing/Midwifery Team to monitor the level of nursing hours required to deliver care on our inpatient wards.

7.4 The data from CHPPD indicates the total amount of care hours delivered to patients over the last four months has remained similar. Each ward maintained a high level of care delivery when comparing the total registered nurses hours available.

7.5 The table below shows the CHPPD hours for each in patient ward over the last four months and indicates the level of need remained stable overall. There is a slight increase in hours of care delivered in July compared to June.

Ward Name	Jul 17	Jun-17	May-17	Apr-17	Mar-17	Feb-17
Gynae 1&2	9.9	8.5	7.0	8.1	7.0	7.2
Mat Base	6.0	6.4	5.9	6.4	6.0	6.5
MLU	42.0	34.3	40.4	42.4	37.0	35.4
Delivery Suite	33.1	38.1	26.8	36.5	31.3	31.5
NICU	12.6	11.8	10.5	10.1	11.2	12.3
Overall	**13.1**	**12.5**	**11.2**	**12.3**	**11.7**	**12.5**

8.0 Nurse Sensitive Indicators

8.1 Nurse sensitive indicators are monitored and reviewed against the safe staffing numbers to identify if the level of staffing on the clinic areas has affected the quality patient care.

8.2 There were 21 reported incidents against the Nursing staffing indicators for July. Of the incidents reported 17 incidents related to medications and one fall in the gynaecology ward resulting in no

patient harm.

8.3 There were 3 new complaints reported, two relating to delivery suite and one related to Mat Base.

Nurse Sensitive Indicators - July 2017								
Ward	CDT	MRSA	Falls No Harm (N)	Falls Harm (N)	HAPU grade 1&2	HAPU grade 3&4	Drug Admin error	New Complaint
Delivery & Induction Suite	0	0	0	0	0	0	0	2
Mat base	0	0	0	0	0	0	4	1
MLU & Jeffcoate	0	0	0	0	0	0	1	0
NICU	0	0	0	0	0	0	12	0
Gynae Ward	0	0	0	1	0	0	0	0

8.4 All incidents are reviewed by the senior nursing team and corrective actions taken where appopriate.

9.0 Temporary Staff Utilisation

9.1 Temporary staff utilisation and all requests for temporary staff (Bank) (Nursing and Midwifery) are monitored daily by the Heads of Nursing/Midwifery. Bank staffing is reviewed at the Safety Huddle each morning at 9.00 am to ensure effective utilisation. Depending on acuity and capacity of the ward areas bank staff may be cancelled at the 9.00am huddle to ensure the most effective use of additional resources.

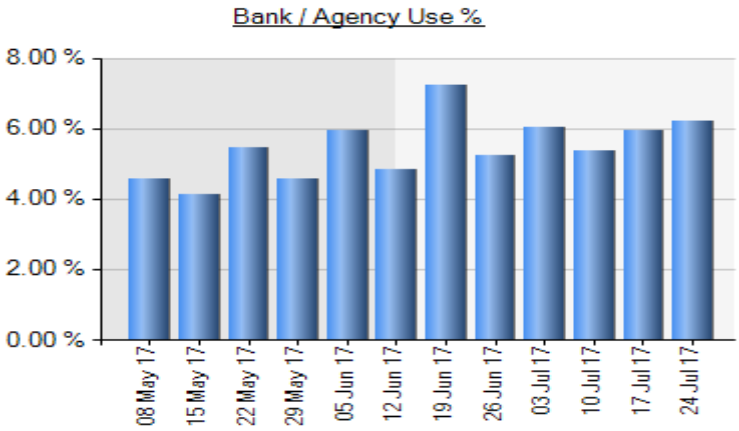
9.2 Monitoring the request for temporary staff in this way serves two purposes:

a) The system in place allows for the most appropriate use of temporary bank staff across the organisation and provides a positive challenge mechanism for all requests.
b) The process allows for an overview of the total number of temporary staff (bank) used in different clinical ward areas and provides a monitoring mechanism for the delivery of safe quality care.

10.0 Bank Usage Inpatient Wards (month ending July)

10.1 The utilisation of bank staff across all inpatient wards is monitored using the Healthroster system. The bar chart below graphically represents total usage of temporary (Bank) staff on inpatient wards month ending July (this is cumulative data captured from roster performance reports). No agency staff were used to replace substantive staff.

10.2 A key performance indicator (KPI) of less than 6% bank usage (bank shifts compared to total shifts assigned) was set to coincide with the NHS England agency cap. The percentage continues to fluctuate and remains below the agreed 6% target.

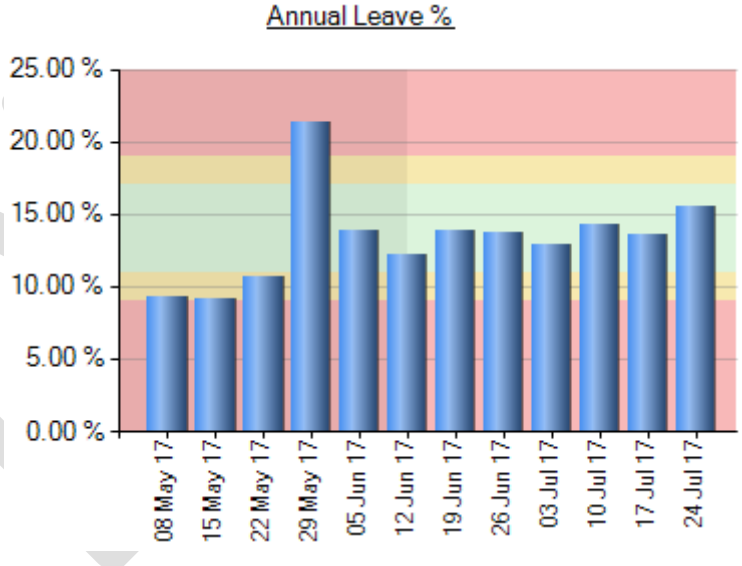


10.3 Temporary staff usage across the inpatient wards fluctuates depending on Nurse/Midwife vacancies and the need to provide additional support.

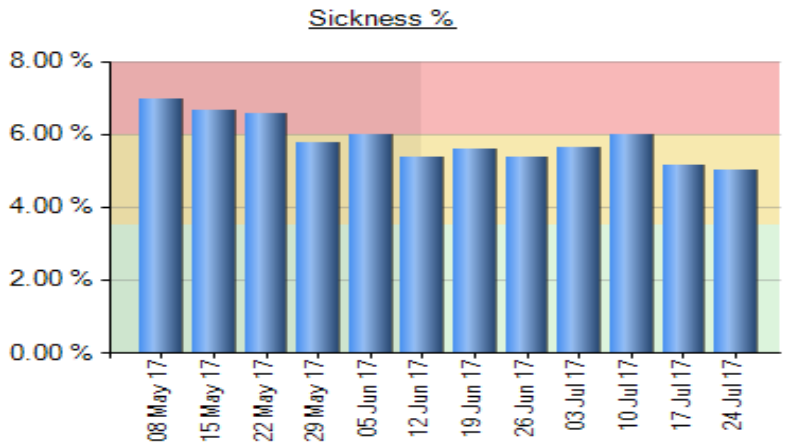
11.0 Managing Staff Resource

11.1 Annual leave taken during July spans the set tolerances of 10% -18%. These tolerance levels ensure all staff are allocated leave appropriately and an even distribution of staff are available throughout the year.

11.2 Heads of Nursing/Midwifery are aware of the need to remind staff to request and take annual leave. This continues to be monitored closely to ensure sufficient staff take annual leave by year end in a consistent manner.



11.3 Sick leave reported in July was above the set parameter of less than 3.5%. Heads of Nursing/Midwifery ensure all individuals reporting back from sick leave undergo a sickness review. Sickness levels are being closely monitored to provide support to all staff.



12.0 Turnover rates

12.1 Turnover rates across the clinical areas have remained static overall for the last four months but with wide variation in different specialities. This is due to a number of factors. All staff that leave the trust are invited to attend an exit interview with the Human Resources department.

12.2 All senior nurse midwife managers are also encouraged to discuss the reasons for leaving the trust with individual members of staff and where deficits have been identified as the cause of the departure, attempt to put these right.

Turnover rates	Apr-17	May-17	Jun-17	Jul-17
Hewitt Centre	10.00%	10.00%	10.00%	12.00%
Genetics	11.00%	8.00%	8.00%	5.00%
Gynaecology	15.00%	12.00%	12.00%	13.00%
Theatres	5.00%	36.00%	21.00%	17.00%
Imaging Services	18.00%	18.00%	6.00%	12.00%
Maternity Services	6.00%	7.00%	7.00%	7.00%
Neonatology	7.00%	7.00%	7.00%	6.00%
Pharmacy	6.00%	6.00%	6.00%	6.00%
Trust Total	**10.00%**	**10.00%**	**10.00%**	**9.00%**

13.0 Professional Registration

13.1 The Director of Nursing & Midwifery monitors all staff professional registrations to ensure all non-medical clinical staff are licensed to practice across the trust. During July one nurse failed to re-register with the Nursing & Midwifery Council and has since left the trusts employ. All other staff remains complaint with the legal requirement to be registered with a professional body.

Professional Registration Lapses	Apr-17	May-17	Jun-17	Jul-17
Hewitt Centre	0	0	0	0
Genetics	0	0	0	0
Gynaecology	0	0	0	1
Theatres	0	0	0	0
Imaging Services	0	0	0	0
Maternity Services	1	0	0	0
Neonatology	0	1	0	0
Pharmacy	0	0	0	0
Trust Total	**1**	**1**	**0**	**1**

14.0 Conclusion

14.1 The Board is asked to note:

- The content of the report and be assured appropriate information is being provided to meet the national and local requirements.

- The organization has the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Director of Nursing & Midwifery

Appendix 1

Updated tables

Fill rate data - summary
July 2017

Day				Night				Average fill rate data- Day		Average fill rate data- Night	
Registered Nurses/ Midwives		Care staff		Registered Nurses/ Midwives		Care staff		Registered Nurses/ Midwives	Care staff	Registered Nurses/ Midwives	Care staff
Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)				
18055	17307.5	5255.5	4738	16893.5	16216	3933	3120	95.9%	90.2%	96.0%	79.3%

Care Hours per Patient Day
February 2017

Cumulative count over the month of patients at 23.59 each day	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
3170	10.6	2.5	13.1

Safer Staffing Fill Rate - Gynaecology					
		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Dec-16	Gynae Ward 1	100.0%	111.1%	98.4%	103.0%
	Gynae Ward 2	93.3%	90.0%	98.8%	96.8%
	Gynae Total	95.8%	98.8%	98.6%	99.9%
Jan-17	Gynae Ward	97.7%	99.9%	100.0%	106.6%
Feb-17	Gynae Ward	96.6%	97.2%	95.8%	95.9%
Mar-17	Gynae Ward	98.4%	95.0%	100.0%	100.0%
Apr-17	Gynae Ward	100.0%	83.3%	99.0%	96.5%
May-17	Gynae Ward	100.7%	100.0%	100.0%	100.0%
Jun-17	Gynae Ward	97.4%	101.2%	93.2%	90.0%
Jul-17	Gynae Ward	101.9%	89.7%	96.7%	96.8%

Safer Staffing Fill Rate - Maternity					
		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Dec-16	Induction & Delivery Suites	87.0%	123.0%	85.0%	84.0%
	Maternity Base	93.0%	85.0%	87.0%	96.0%
	MLU & Jeffcoate	77.0%	50.0%	78.0%	52.0%
	Maternity Total	86.2%	85.7%	83.8%	80.2%
Jan-17	Induction & Delivery Suites	88.2%	106.5%	89.0%	93.4%
	Maternity Base	86.7%	83.2%	84.3%	94.6%
	MLU & Jeffcoate	90.9%	93.5%	88.7%	93.5%
	Maternity Total	88.3%	90.3%	87.8%	94.0%
Feb-17	Induction & Delivery Suites	87.2%	114.3%	91.4%	67.9%
	Maternity Base	98.5%	84.3%	98.8%	73.2%
	MLU & Jeffcoate	80.4%	100.0%	90.3%	96.4%
	Maternity Total	88.5%	93.8%	92.8%	74.1%
Mar-17	Induction & Delivery Suites	85.4%	111.3%	91.4%	79.6%

	Maternity Base	97.7%	78.7%	100.0%	92.5%
	MLU & Jeffcoate	84.4%	93.5%	88.7%	93.5%
	Maternity Total	88.2%	88.7%	92.7%	87.1%
Apr-17	Induction & Delivery Suites	89.6%	108.7%	93.3%	89.7%
	Maternity Base	95.1%	80.0%	98.3%	88.9%
	MLU & Jeffcoate	87.2%	96.7%	89.4%	96.7%
	Maternity Total	90.4%	90.0%	93.6%	90.3%
May-17	Induction & Delivery Suites	85.7%	121.0%	90.5%	83.9%
	Maternity Base	95.4%	84.5%	98.9%	67.7%
	MLU & Jeffcoate	83.9%	96.8%	80.1%	96.8%
	Maternity Total	87.6%	95.2%	90.1%	77.4%
Jun-17	Induction & Delivery Suites	84.5%	118.0%	87.1%	88.9%
	Maternity Base	90.0%	80.7%	81.4%	75.0%
	MLU & Jeffcoate	91.1%	100.0%	79.2%	93.3%
	Maternity Total	87.3%	92.5%	84.0%	82.5%
Jul-17	Induction & Delivery Suites	85.8%	132.3%	91.4%	82.8%
	Maternity Base	85.9%	76.1%	80.2%	84.4%
	MLU & Jeffcoate	87.6%	87.1%	81.7%	93.5%

	Maternity Total	86.2%	91.0%	86.4%	85.0%

Safer Staffing Fill Rate - Neonatal Care					
		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Dec-16	Neonatal Care	103.8%	51.6%	99.8%	51.6%
Jan-17	Neonatal Care	106.5%	66.1%	106.0%	50.0%
Feb-17	Neonatal Care	104.5%	73.2%	105.4%	48.2%
Mar-17	Neonatal Care	104.4%	74.2%	105.4%	51.6%
Apr-17	Neonatal Care	105.4%	55.0%	107.3%	41.7%
May-17	Neonatal Care	109.7%	56.5%	109.9%	38.7%
Jun-17	Neonatal Care	109.8%	56.7%	109.8%	46.7%
Jul-17	Neonatal Care	111.9%	87.1%	112.3%	41.9%

Liverpool Women's NHS Foundation Trust

Agenda Item	2017/248 (i)

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Health and Safety Annual Report 2016/17**
DATE OF MEETING:	Friday, 01 September 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Doug Charlton, Director of Nursing and Midwifery
AUTHOR(S):	Tracy Bryning, Health & Safety Manager

STRATEGIC OBJECTIVES:	***Which Objective(s)?***	
	1. To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒
	2. To be ambitious and ***efficient*** and make the best use of available resource	☒
	3. To deliver ***safe*** services	☒
	4. To participate in high quality research and to deliver the most ***effective*** Outcomes	☐
	5. To deliver the best possible ***experience*** for patients and staff	☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***	
	1. *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust*	☒
	2. *The Trust is not financially sustainable beyond the current financial year*	☐
	3. *Failure to deliver the annual financial plan*	☐
	4. *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision*	☐
	5. *Ineffective understanding and learning following significant events*	☐
	6. *Inability to achieve and maintain regulatory compliance, performance and assurance*	☐
	7. *Inability to deliver the best clinical outcomes for patients*	☐
	8. *Poorly delivered positive experience for those engaging with our services*	☒
CQC DOMAIN	***Which Domain?***	
	SAFE- *People are protected from abuse and harm*	☒
	EFFECTIVE - *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.*	☐
	CARING - *the service(s) involves and treats people with compassion, kindness, dignity and respect.*	☐
	RESPONSIVE – *the services meet people's needs.*	☐
	WELL-LED - *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.*	☒
	ALL DOMAINS	☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution	☐	**4.** NHS Constitution	☐
	2. Operational Plan	☐	**5.** Equality and Diversity	☐
	3. NHS Compliance	☒	**6.** Other: Click here to enter text.	

FREEDOM OF INFORMATION (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 receive the report and assurance provided through GACA.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Governance and Clinical Assurance Committee Or type here if not on list: *Click here to enter text.*
	Date of meeting	Thursday, 17 August 2017

Executive Summary

This report was presented to the Governance and Clinical Assurance Committee to provide an overview of compliance and governance assurance regarding the Health and Safety arrangements, activities, performance and improvements for Liverpool Women's NHS Foundation Trust.

The work plan in Section 8 also details future improvements and activities, demonstrating the Trust's commitment to effective health and safety management and continuing improvements in health and safety performance.

Report

1. Introduction

This report provides an overview of the main areas of work within Health and Safety since its relocation of line management responsibility from Governance to the management of Estates and Facilities in February 2017.

Since the Health and Safety Annual report was presented in July 2016 there has been good progress made in the development of our health and safety systems.

Whilst progress has been made in relation to the overall health and safety management system, it is clear from the results of a full gap analysis, undertaken in February 2017; that there is some scope for improvement, particularly in relation to the frequency of Health and Safety Committee Meetings held since the establishment of the Safety Senate.

2. Key Objectives and Current Situation

2.1 Health and Safety Annual Workplace Assessments

Statutory and mandatory annual health and safety workplace assessments and action plans are historically completed by the end of February 2017 for all departments. The February deadline is to enable the whole site health and safety workplace assessment to be completed and to create an action plan that is deliverable in time for year-end budgeting.

The greater majority of the Crown Street site satisfactorily completed the annual workplace assessment; with the exception of the Gynaecology Service where an extension to the deadline was accepted, due to changes in senior manager and the current building works.

The Knutsford Hewitt Centre and the Aintree facilities also satisfactorily completed annual health and safety workplace assessments

The 94 community locations staffed by the Community Midwifery Service, currently have no up to date statutory workplace risk assessments for our staff working in these premises. However, close liaison to review and resolve health and safety matters e.g. vermin infestation at one premise and general absence of health and safety related incident reporting, is ongoing with the Maternity Matron for Community. An appropriate risk register entry has been made, reflecting current issues and how risks are being managed.

2.2 Health and Safety Training

The annual workplace assessments identified a need to increase the numbers of departmental DSE (display screen equipment) and COSHH Control of Substances Hazardous to Health)

Assessors; this has been reflected in local risk assessments and action plans in working to resolve the shortfall of appropriately trained assessors.

Health and safety best practice is to appoint a trained Representative of Employee Safety (RES) per department and insufficient numbers were also highlighted during the recent annual workplace assessments.

Provision of training for these roles can support our managers, leaders and employees to meet their health and safety duties and responsibilities; as well as meeting organisational, legal and regulatory health and safety responsibilities. Good progress is being made, with certificated training sessions recently being delivered to 16 new DSE Assessors and 13 new COSHH Assessors across the Trust.

Certificated Health and Safety Awareness Training courses, aimed at newly nominated Representatives of Employee Safety and supervisors with local responsibility for the health, safety and wellbeing of staff and visitors, have been delivered in June 2017. These courses are also a useful refresher for managers and leaders who have previously obtained an IOSH (Institute of Occupational Safety and Health) qualification.

Re-introduction of IOSH training for AfC bands 6/7 upwards has commenced, with the first, fully booked, four day IOSH accredited course being delivered by Rawlings RCS in June 2017. Further courses will be offered throughout 2017/18 to AfC bands 5/6 upwards, in the first instance.

Health and Safety legislation requires employers to provide adequate health and safety training and employers have a general duty to provide information, instruction, and training and to provide a safe place of work, under Section 2 of the Health and Safety at Work etc. Act 1974.

The Manual Handling Operations Regulations (1992) sets out a hierarchy of measures to reduce the risks of manual handling in the workplace, so far as are reasonably practicable. These measures include access to specialist advice, access to suitable and sufficient training programs, provision of manual and load handling equipment to reduce the risks and adequate risk assessments.

Presently the Trust carries a vacancy for a training lead for manual and load handling and this has been recorded on the Risk Register. The Health and Safety Manager is working closely with the Learning and Development Team and clinical leads to source a level 3 accredited Train the Trainer course and identify potential staff members to fulfil the role.

2.3 Policies & Standard Operating Procedures (SOP's)

All Health and Safety related policies are currently being updated to reflect changes in the health and safety management structure, roles and responsibilities.

Policy Title	Formal Review Date
Health and Safety Policy	01/07/19
New and Expectants Mothers Policy	01/12/17
CAS Policy	01/12/17
Toy Cleaning Policy	23/07/18
Safer Use of Sharps Policy	New – out for consultation

There are presently 5 Health and Safety associated categories within the Health and Safety Policy. In 2014 the 5 health and safety categories of DSE, COSHH, First Aid, Moving and Handling and Slips, Trips and falls were devolved from the Policy document into Standard Operating Procedures (SOPs), so as to simplify Policy documentation. The SOP's contain

references to specific related legislation and mandatory requirements and it is recommended that further consideration and discussion be given to the reinstatement of Manual and Load Handling SOP and COSHH SOP, to Policy status.

2.4 Safety Software System

The Estates and Facilities Team including Health and Safety are developing pro-forma documents for risk assessment and performance monitoring, for use with the recently procured BORIS Safety Software System. Purchased in March 2017, this project is currently underway and it is envisaged will significantly reduce and improve upon the amount of paper based health and safety related audits and assessments. It will also provide an overarching health and safety dashboard, highlighting key performance indicators for compliance, performance and gaps in health and safety arrangements.

2.5 H&S Management Arrangements

Employers have a duty to consult with their employees, or their representatives, on health and safety matters. Communication is key to an effective health and safety system and industry best practice is to apply a reflective and collaborative learning stance to health and safety incident investigation. It is a good practice for large organisations to establish and maintain a Health and Safety Committee, where the Committee should provide a link between staff doing the work and the people directing it.

The Health & Safety Committee and supporting risk management working groups should aim to identify and mitigate risk through lessons learned, to reduce accidents and incidents, improve health and safety awareness, provide a broad base of expertise and experience for solving problems and in engaging staff, so that concerns can be raised and addressed, as appropriate.

Health and Safety Management falls within the portfolio of the Director of Nursing and Midwifery. The Health and Safety Committee has convened twice in the last 12 month reporting period and should ideally meet quarterly. It is recommended that the Health and Safety Management arrangements are reviewed and agreed with the Director of Nursing and Midwifery so as to appropriately ensure good governance assurance and compliance with health and safety statutory requirements and industry best practice. Formal meeting arrangements are currently in discussion with the Director of Nursing and Midwifery.

3. Reported Incidents

In the reporting period 2016/17 there were 112 non-clinical Health & Safety incidents reported which is a decrease of 184 on last year's total of 296. The substantial decrease is largely attributed to the separate reporting of security related incidents via the quarterly and annual Security Management report by the Trust LSMS. For a comparison between reported incidents in 2014/15, 2015/16 and 2016/17 see table 1 below.

Table 1 – Non Clinical Health & Safety Incidents by Cause

Cause:	2014/15	2015/16	2017/18
Collapse	11	0	2
Collision/Contact	11	10	5
Communication	6	3	0
COSHH	5	3	5
Environment	7	4	9
Equipment	0	1	3
Illicit Drugs	0	1	0

Injury	19	37	20
Manual Handling	4	2	7
Security	35	117	n/a
Sharps/NSI	25	44	27
Slip, Trip, Falls	32	32	34
Staff Illness	2	3	0
Stress	0	0	0
Traffic	0	2	0
Violence & Aggression	27	37	n/a
Annual Totals	**184**	**296**	**112**

The three primary causes of incidents are categorised as needlestick incidents, slip trip and falls and injury. Further analysis of these cause groups are detailed in the following tables and narrative.

3.1 Sharps (NSI) and Splash Incidents (Exposure to BBV)

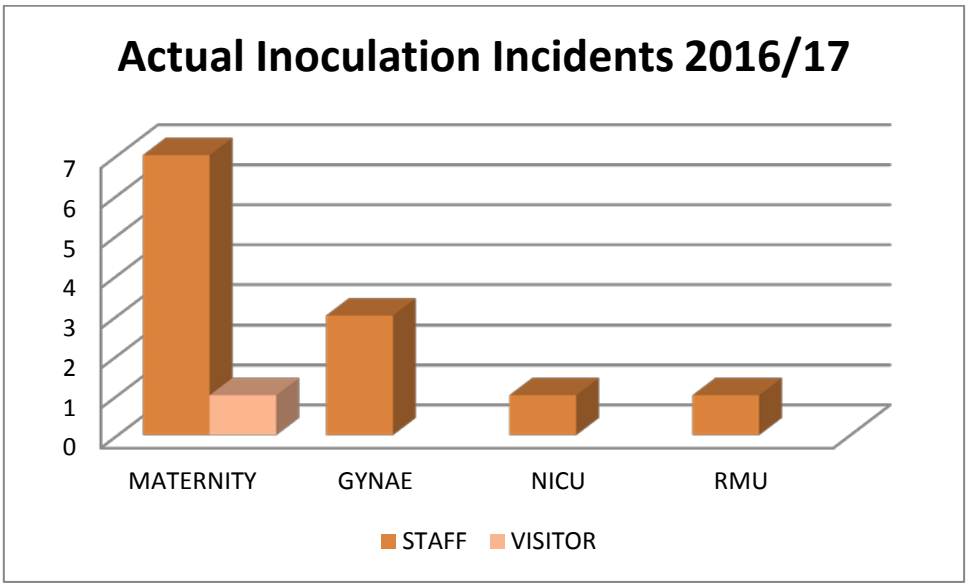
Inoculation incidents may be subdivided into two categories. Those resulting from percutaneous exposure which occurs as a result of a needlestick or a medical sharp contaminated with blood or bodily fluid; and those resulting from mucocutaneous exposure which occur when bodily fluids come in to contact with open wounds or mucous membranes such as the mouth and eyes. There are more than 20 pathogens that can be transmitted following a needlestick (NSI) or sharps injury. The most common are Hepatitis B, Hepatitis C and HIV and, therefore, are a significant occupational hazard to healthcare professionals.

The total number of inoculation incidents in 2016/17 was **27. 16** of these incidents involved percutaneous exposure to needles, scalpels and cannulas, etc. There were **11** incidents recorded as near miss events.

The annual audit of inoculation incidents has shown staff related inoculation incidents totalling **7** within Maternity Services, **5** in Gynaecology Services including 2 near miss events, **8** in NICU including 3 near miss events, **1** in the Hewitt Centre, 1 near miss event each in Cytogenetics and the Bedford Clinic. Incidents reported by Estates and Facilities have remained low for the past 3 years, however, there were **3** near miss incidents involving gardening volunteers finding discarded syringes around the grounds. There was **1** injury to a patient who trod on a shard of glass within the Midwifery Led Unit.

Table 2 details the types of inoculation incidents that were reported by the Services in 2016/17.

Table 2 – Inoculation Incidents by Service 2016/17



The majority of inoculation incidents were injuries from hollow bore needles **(9)**, CFM needles **(3)**, suture needles **(1),** scalpel **(1),** lancet **1** and **1** of glass. In all reported incidents appropriate treatment pathways were followed.

12 incidents were recorded as near misses when needles were not disposed of appropriately and could have resulted in a needle stick injury.

In previous years reporting, the Occupational Health Manager and Health and Safety Manager have undertaken a comparison of incidents reported to Occupational Health with those reported formally via the Trust web incident reporting system. Recent years had highlighted significant discrepancies of incidents that were reported to Occupational Health but that did not have a web incident form completed. Staff members without a formal incident report were previously individually written to by the Health and Safety Manager for further discussion and appropriate action. An audit has identified that the Occupational Health Service has not maintained its record of needlestick injuries for the past finanical year. New arrangements have been made with the Aintree Lead for Occupational Health to provide quarterly and annual reports to the Health and Safety Manager for the purposes of cross reference and to ensure the Trust is capturing and reporting upon all needlestick related incidents. Therefore, it can be assumed that the figures quoted from Ulysses data will reflect an under reporting.

There were no RIDDOR related sharps or splash incidents.

As in previous years, injuries remain significant for poor disposal of sharps and injuries to colleagues.

The use of Sharpsmart continues and is still offering good value. We have recently introduced C64 size for disposal of lines but this is only into NICU and Theatres. These C64 are not certificated for Sharps and the users have been made aware of this.

A review of an alternative supplier (SRCL) did take place but did not provide any additional benefits to what we currently receive.

Ongoing audits are carried out both at factory level where the containers are opened, photographed and checked for non-compliant contents. The onsite audits look at usage and whether the documentation is correct and complete, this is one shortfall that has been identified.

Ongoing training continues to be delivered by the auditor whenever any ‘bad practices’ are observed or evidenced.

No issues have been raised over any safety aspects of the system.

The Trust has been nominated for several awards together with Sharpsmart, the high point of which was winning the national recycling awards.

Following discussion at the Infection and Prevention Control Committee, it was agreed that the Management of Sharps and blood bourne viruses (BBV) Policy was to be archived in favour of a separate Management of Blood Bourne Viruses Policy and Safer Use of Sharps Policy; the latter is currently being consulted upon.

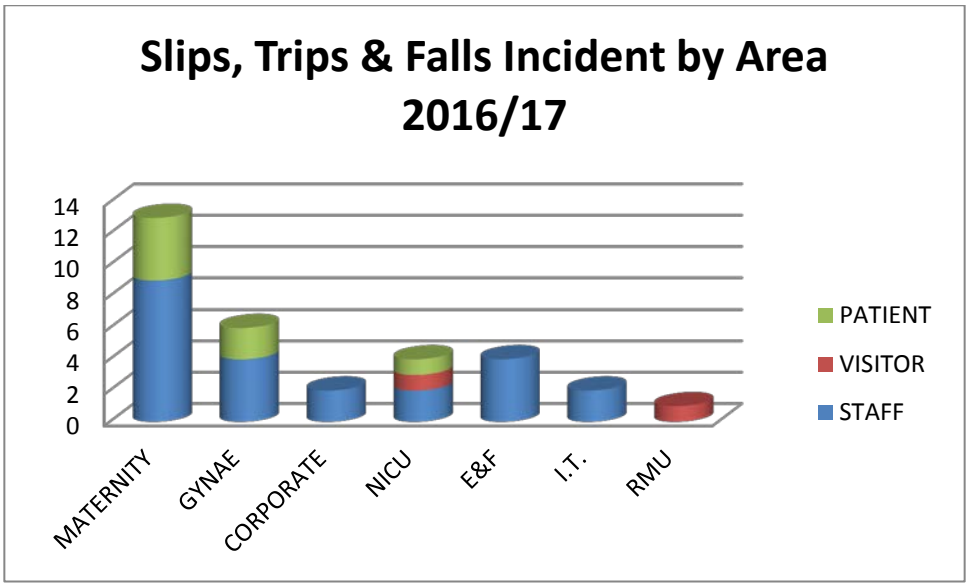
3.2 Slips, Trips and Fall Incidents

There were a total of **34** slips, trips and falls incidents reported during 2016/17; an increase of 2 from the previous year. The majority of slip, trips and falls incidents were reported by Maternity Services **(14)** - **1** of which involved a baby falling or slipping from its mothers arms. The baby was appropriately assessed, as per protocol and suffered no injuries. Gynaecology Services reported **9** incidents; NICU and Estates & Facilities reported **4** incidents; Governance and IT each reported **2** incidents; Corporate Services had **1** incident; and RMU reported **1** incident.

There was a trend of both staff and patients slipping on liquid spillages, several of which were reported to be from hand gel. Guidance and advice with regards to dealing with spillages has been issued to all staff and is regularly refreshed at mandatory training updates.

A full breakdown of slips, trips and falls incidents by area is tabled below:

Table 3 – Slip, Trip & Fall Incidents by Area 2016/17

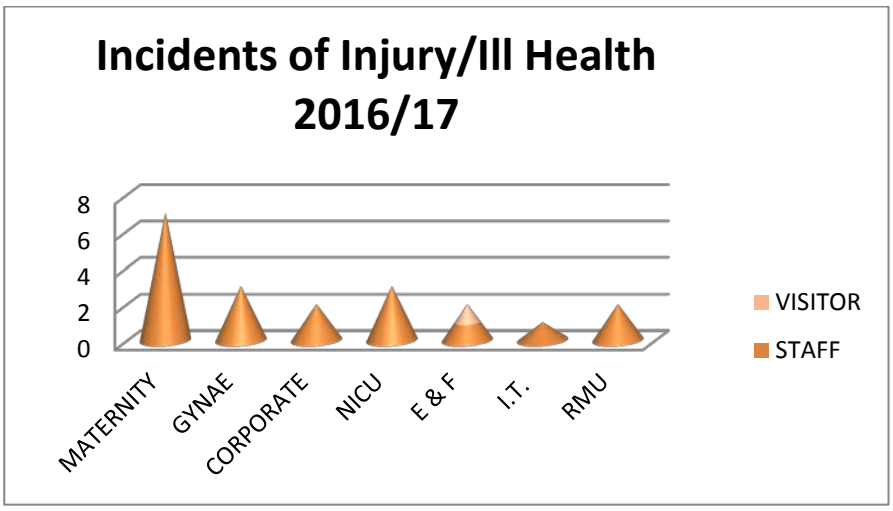


Slips, trips and falls related RIDDOR's (Reporting of Injuries, Diseases & Dangerous Occurrences Regulations) are looked at in the following section – RIDDORS

3.3 Personal Injury/Ill Health

Of the **20** recorded injury incidents, a decrease of **17** from the previous reporting period; the majority were one-off unconnected accidents. All those affected by injuries received appropriate care including attendance of local A&E department.

Table 4 – Personal Injury/Ill Health Incidents by area



Personal injury incidents were reported across the Trust with Maternity Services recording the highest numbers of incidents at **7**; **3** incidents were reported each from NICU and Gynaecology Services. Corporate Services, RMU and Estates & Facilities each recorded **3** injury related incidents including one visitor accident. The visitor walked into a sign post in the visitor car park sustaining a bump and cut to his head. First Aid was delivered and the individual was advised to attend local walk in centre or A&E department if any ill effects caused concern. A decision was taken to relocate the sign post.

There was one injury reported to have been received by a staff member within IT Services.

There was a trend seen involving accidents occurring with office chairs; one of which was RIDDOR reportable with the staff member receiving a significant knee injury. A whole site audit of office chairs was undertaken and local manager's advised of any actions required. An all staff communication was issued with regards to safe use of office chairs and, in particular, the types of castors required for different flooring types. The issue was discussed at Health and Safety Committee.

All incidents notified were dealt with and recorded appropriately.

4. RIDDORS

The Trust is required to submit RIDDOR reportable incidents to the HSE within prescribed timescales. Persistent late reporting exposes the Trust to potential prosecution for non-compliance with the regulations. The Trust is 100% compliant in meeting reporting deadlines, within the last reporting period.

There were 6 RIDDOR's reported to the HSE in 2016/17 which is an increase of 4 on last year's total of 2 RIDDORs.

All of the incidents reported were in unique, accidental circumstances. Staff received appropriate care and support.

Department	Cause Group	Reportable Injury or Over 7 Day Absence
Community	Collision (RTA)	Over 7 day absence – soft tissue injury
Governance	Slip	Broken bone in foot
NICU	Slip	Over 7 day absence - sprain
Obs Theatre	Slip	Over 7 day absence – soft tissue injury
Estates	Manual Handling	Over 7 day absence – soft tissue injury

Corporate	Fall	Over 7 day absence - Ruptured Tendon

5. Legal Claims

The Legal Team at Liverpool Women's Trust has advised that there are no non- clinical Health & Safety related claims within the past financial year and no claims that have reached settlement.

6. Health & Safety Executive (HSE) Priority Objectives 2017/18

The HSE priority themed objectives for 2017/18 are: -

- Lead and engage with others to improve workplace health and safety
- Provide an effective regulatory framework
- Secure effective management and control of risk
- Reduce the likelihood of low-frequency, high-impact catastrophic incidents

7. Health and Safety work plan for 2017/18

Health & Safety Work Plan 2017/18		
Actions	**Responsible Persons**	**Completion Date**
Work with Director of Nursing and Midwifery to establish a robust safety management system, as per HSG65	Health & Safety Manager	March 2018
Continue to address gaps in the health and safety checklist	Health & Safety Manager	On-going
Further review, audit and develop health and safety policies and SOPs	Health & Safety Manager	On-going
Monitor health and safety incidents. Providing quarterly incident reports to the Health & Safety committee.	Health & Safety Manager	On-going
Report RIDDORs to the HSE	Health & Safety Manager	On-going
To continue to modernise Health & Safety annual workplace audits and introduce electronic solutions through the development of BORIS Safety Software System	Health & Safety Manager	On-going
Continue to review and improve upon health & safety training provision	Health & Safety Manager	September 2016
Roll Out Chemical Clearance Programme & COSHH Register through development of Safety Software System	Health & Safety Manager	January 2018

8. Recommendations

The Board is asked to receive the report and assurance provided through GACA.

9. Appendices

Appendix 1 – Health and Safety Organisational Checklist and Gap Analysis

Appendix 2 – HSE Business Plan 2017/18

Appendix 3 – Definitions

- DSE (display screen equipment)
- COSHH (Control of Substances Hazardous to Health)
- RES (Representative of Employee Safety)
- IOSH (Institute of Occupational Safety and Health)
- Standard Operating Procedures (SOPs)
- Needlestick (NSI)
- Blood bourne viruses (BBV)
- RIDDOR's (Reporting of Injuries, Diseases & Dangerous Occurrences Regulations)
- Health & Safety Executive (HSE)

Appendix 1

Liverpool Women's NHS Foundation Trust

Liverpool Women's H&S Self-Assessment/Gap Analysis V1.1 Working Document 2017

POLICY	Fully met (Score 2)	Partially met (Score 1)	Not met at all (Score 0)	Evidence	Gap	Action/Recommendation	Action by whom?	Completion Date
1. The company understands its responsibilities for H&S towards employees, customers, visitors and members of the public and has a clear, written policy for health and safety at work, signed, dated and communicated to all employees.	2			H&S Policy Intranet		*Survey small sample of staff*	*TB*	
2. The Directors regard health and safety of employees as an important business objective.		1			*H&S Committee has only convened twice in an 18 month period*	*Establish terms for H&S Management System going forward* *Promote safety culture* *Reinforce responsibilities*	*TB/IH/DC*	
3. The Directors are committed to continuous improvement in health and safety (reducing the number of injuries, cases of work-related ill health, and absences from work and accidental loss).		1			As 2.	*Establish terms for H&S Management System going forward* *Promote safety culture*	*TB/IH/DC*	
4. A named Director or Senior Manager has been given overall responsibility for implementing our health and safety policy.	2			Director of Nursing & Midwifery identified in Policy				

5. Our policy commits the Directors to preparing regular health and safety improvement plans and regularly reviewing the operation of our health and safety policy.		1		H&S Policy Policy QA Group	Requires Policy amendment	*Amend policy following reinforcement of Directors responsibilities*	*TB*	
6. Our policy includes a commitment to ensuring that all employees are competent to do their jobs safely and without risks to health.	2			H&S Policy				
7. Our policy encourages the involvement of employees and safety representatives in the health and safety effort.	2			H&S Policy				
POLICY SCORES	8	3						
TOTAL SCORE (Maximum = 14)	11							
For advice on H&S policies see Chapter 2 of HSG65 or page 2 of free leaflet INDG275 and http://www.hse.gov.uk/simple-health-safety/write.htm *For advice re leadership see* http://www.hse.gov.uk/leadership/smallbusinesses.htm								

ORGANISING CONTROL	**Fully met (Score 2)**	**Partially met (Score 1)**	**Not met at all (Score 0)**	**Evidence**	**Gap**	**Action/Recommendation**	**Action by whom?**	**Completion Date**
1. We have identified the people responsible for particular health and safety jobs including those requiring special expertise (e.g. our health and safety advisor).	2			H&S Manager in post Staff side H&S Rep Limited number of local H&S Reps	Lack of resilience, e.g. part time employees /lone worker, capacity	*Review cover arrangements, staffing level, resilience, recruit local H&S RES and provide appropriate training*	*TB/IH*	
2. Our company responsibilities for all aspects of health and safety have been defined and allocated to our managers, supervisors and team leaders.	2			H&S Policy Employee Contract				

3. Our managers, supervisors and team leaders accept their responsibilities for health and safety and have the time and resources to fulfil them.		1		H&S Policy Employee Contract	Untested Unassured	*Audit of responsible managers and training needs analysis*	*TB*	
4. Our managers, supervisors and team leaders know what they have to do to fulfil their responsibilities and how they will be held accountable.		1		H&S Policy Employee Contract				
ORGANISING CONTROL SCORES	4	2						
TOTAL SCORE (Maximum = 8)	6							
For advice on the essential elements of organisation control see page 17 of HSG65 and page 6 of ING275.								

ORGANISING COMMUNICATION	**Fully met (Score 2)**	**Partially met (Score 1)**	**Not met at all (Score 0)**	**Evidence**	**Gap**	**Action/Recommendation**	**Action by Whom?**	**Completion Date**
1. We provide clear information to people working on our site about the hazards and risks and about the risk control measures and safe systems of work (which is easily accessible in the relevant work area).		1		Intranet usage H&S Noticeboard Annual HSAWA Leaflet Communications media	Untested Unassured	*Audit to be undertaken and action plan updated from findings*	*TB*	
2. We discuss health and safety regularly and health and safety is on the agenda of management meetings and briefings.		1			Untested Unassured	*Audit to be undertaken and action plan to be updated from findings*	*TB*	
3. Our directors, managers and supervisors are open and approachable on health and safety issues and encourage their staff to discuss health and safety matters.		1			Untested Unassured	*Audit to be undertaken and action plan to be updated from findings*	*TB*	

4. Our Directors, Managers and Team Leaders communicate their commitment to health and safety through their behaviour and by always setting a good example.		1			Untested Unassured		*TB*	
5. We provide clear information to persons working on behalf of the organisation (i.e. contractors, visiting drivers) regarding site hazards and risks and about the control measures in place to protect them.	2			Contractors induction Contractors RAMS	Align IT and Estates best practice and management of onsite contractors			
6. We provide clear information to casual and irregular visitors to the site (i.e. customers, school visits, auditors) regarding site hazards and risks and about the control measures in place to protect them.		1		Placement Provider Health and Safety Procurement Standards 1-9 Work Experience Procedure/ risk assessment	Untested Unassured	*Audit to be undertaken of H&S arrangements for casual visitors and the action plan updated from findings*	*TB*	
7. We have established clear feedback systems to customers on safety issues, such as drivers breaching traffic rules, climbing on loads, not wearing PPE etc.	2							
ORGANISING COMMUNICATION SCORES	4	5						
TOTAL SCORE (Maximum = 14)	9							
For advice on communications see page 23 of HSG65 and page 6 of IND275								

Appendix 1

ORGANISING CO-OPERATION	Fully met (Score 2)	Partially met (Score 1)	Not met at all (Score 0)	Evidence	Gap	Action/Recommendation	Action by Whom	Completion Date
1. We involve the workforce in preparing health and safety improvement plans, reviewing our health and safety performance, undertaking risk assessments, preparing safety-related rules and procedures, investigating incidents and problem solving.		1		Staff Side H&S Rep engagement H&S Reps (minimal)	Workforce may be under represented Managers/leads would benefit from support	*Establish terms for H&S Management System going forward* *TOR's* *Recruit and train RES's in house* *Create appropriate minuted meetings/forums, TORs* *Create area checklists for H&S/Estates related items, findings to be shared at team meetings*	*TB/IH/DC*	
2.We consult our employees and employee safety representatives on all issues that affect health and safety at work		1		Staff Side H&S Rep engagement H&S Reps (minimal)	Establish terms for H&S Management System going forward	*Establish appropriate, minuted committees/forums and TORs*	*TB/IH/DC*	
3. We have an active health and safety committee that is chaired by the appropriate Director or Senior Manager and on which employees from all departments are represented.			0		Establish terms for H&S Management System going forward	*Establish appropriate, minuted committees/forums and TORs*	*TB/IH/DC*	
4. For contractors and employment agencies whose employees work on our site, we have arrangements for cooperating and coordinating on health and safety matters.	2			All Trust policies apply Contractors Induction Corporate Induction rams				

ORGANISING CO-OPERATION SCORES	2	2						
TOTAL SCORE (Maximum = 8)	4							
For advice organising co-operation see page 22 of Chapter 3 of HSG65 and page 6 of INDG275 *For worker involvement and consultation see also:* *http://www.hse.gov.uk/involvement/index.htm* *http://www.hse.gov.uk/simple-health-safety/consult.htm*								

ORGANISING COMPETENCE	Fully met (Score 2)	Partially met (Score 1)	Not met at all (Score 0)	Evidence	Gap	Action/Recommendation	Action by Whom	Completion Date
1. We have a system for ensuring that all our employees, including managers, supervisors and temporary staff, are adequately instructed and trained.		1		OLM Training Records Local and Corporate Induction Workbooks Coreskills Framework Mandatory Training Matrix H&S Policy	No Assurance Lack of H&S speciality training as in 3 and 4	*Audits to be undertaken and the action plan updated from findings* *Ensure training is regularly available and deliverable* *Utilise BORIS*	*JA*	
2. We have assessed the experience, knowledge and skills needed to carry out all tasks safely.	2			Mandatory Training Matrix				
3. We have a system for ensuring that people doing particularly hazardous work or exposed to hazardous situations have the necessary training, experience and other qualities to carry out the work safely.		1		Local and Corporate Induction SOPs OLM Training Records Mandatory Training Matrix Workbooks Coreskills Framework rams	Not assured, limited DSE and COSHH Assessors	*Audits to be undertaken and the action plan updated from findings* *Recruit and train DSE and COSHH Assessors* *Utilise BORIS*	*TB*	
4. We have arrangements for		1		MH Paper to Execs Jan 17	Load and Manual	*Trust to review options for*	*JA*	

gaining access to specialist advice and help when we need it.				MH Report 2016 Training Records AEs	Handling – no lead/trainer for Trust	*access to, sharing services or employing MH Lead*		
5. We have systems for ensuring that competence needs are identified and met whenever we take on new employees, promote or transfer people or when people take on new health and safety responsibilities e.g. when we restructure or reorganise.		1		Cascade Trainers Local and Corporate Induction SOPs H&S Policy OLM Training Records Mandatory Training Matrix Workbooks Coreskills Framework TNA's Competencies	Not fully assured,	*as in 1, 3 and 4*	TB/JA	
6. We have systems for the selection of contractor companies and their personnel entering our organisation. Before contracts are agreed upon we ensure they have the right level of technical and safety competence.	2			Procurement Policy and Process NW Consortium Framework Approved Frameworks e.g. gas safety, electrical, water, fire				
7. We have systems for ensuring that competence needs are identified and met whenever we take on contracted or agency personnel and we have systems to assess the individual can carry out tasks safely.	2			Contractors Induction Company Training/Risk Assessment documentation Approved Framework				
ORGANISING COMPETENCE SCORES	6	4						
TOTAL SCORE (Maximum = 14)	10							

For advice on competence see page 22 of Chapter 3 of HSG65 and page 6 of INDG275
For training see also: http://www.hse.gov.uk/simple-health-safety/provide.htm
For competent advice: http://www.hse.gov.uk/simple-health-safety/decide.htm and http://www.hse.gov.uk/business/competent-advice.htm

Appendix 1

PLANNING AND IMPLEMENTING	Fully met (Score 2)	Partially met (Score 1)	Not met at all (Score 0)	Evidence	Gap	Action/Recommendation	Action by Whom	Completion date
1. We have a system for identifying hazards, assessing risks and deciding how they can be eliminated or controlled.	2			H&S Policy Risk Management & Incident Reporting Policy Mandatory Training Matrix OLM Training Records Ulysses Area Quality Meetings				
2. We have a system for planning and scheduling health and safety improvement measures and for prioritising their implementation depending on the nature and level of risk.		1		Risk Strategy Risk Register	Not fully assured	*Establish terms for H&S Management System going forward*	*TB*	
3. We have arrangements for agreeing measurable health and safety improvement targets with our managers and supervisors.		1		Working towards KPIs	Not assured	*Establish terms for H&S Management System going forward*	*TB*	
4. Our arrangements for purchasing premises, plant, equipment and raw materials and for supplying our products take health and safety into account at the appropriate stage, before implementation of the plan or activity.	2			Procurement Policy and Process General Risk Assessments				

5. We take proper account of health and safety issues when we design processes, equipment, procedures, systems of work and tasks.		1		Estates compliance General Risk Assessments Generic Risk Assessments	Not assured for rest of Trust	*Audits to be undertaken and the action plan updated from findings* *Raising H&S Profile current project* *IOSH Training and H&S Awareness Training being offered to managers*	*TB*	
6. We have procedures for dealing with serious and imminent dangers and emergencies.	2			H&S Policy EPRR Policy BCM Policy BCP's Fire Policy CAS Policy & Procedure Bomb Threat and Suspect Packages Policy HTMs				
7. We have health and safety rules and procedures covering the significant risks that arise in our day-to-day work activities including normal production, foreseeable abnormal situations and maintenance work.	2			H&S SOPs H&S Policy Estates compliance General Risk Assessments Generic Risk Assessments HTMs				
8. We set standards against which we can measure our health and safety performance.		1		SEE Report Incident Reporting KPIs		*Development of BORIS software will create performance dashboards for all areas*	*TB*	
9. We have formally stipulated and agreed safety specifications for static plant and equipment used within our organisation, they include	2			Procurement Policy and Process Estates Compliance HTMs				

requirements to fit certain safety control devices as required i.e. interlock systems, guarding, e-stops etc.				ACOPs				
10. We have formally stipulated and agreed safety specifications for mobile plant and vehicles (whether owned, contract hired or leased) and they include requirements to fit certain safety devices as required i.e. reversing cameras, autosheeters.	2			Procurement Policy and Process Estates Compliance				
11. We have arrangements for dealing with unplanned / ad hoc work activities, in identifying the hazards, assessing the risks and deciding how they can be eliminated or controlled.	2			H&S Policy EPRR Policy BCM Policy BCP's General Risk Assessments CAS Policy & Procedure RAMs				
12. We have arrangements for dealing with emergency situations, which includes assigning certain roles and responsibilities to persons.				H&S Policy EPRR Policy BCM Policy BCP's Fire Policy Bomb and Suspect Packages Policy CAS Policy & Process				
13. We have arrangements for managing work which is identified as having a particular high risk and requires stricter controls. The work is carried out against previously agreed safety procedures, a 'permit-to-work' system.	2			Procurement Policy and Process Estates Compliance HTMs/Permit-to-Work				

14. We have arrangements for ensuring that unauthorised operation of plant and equipment is effectively prevented.	2			Estates Compliance Security/Entry Locks					
15. We have arrangements for performing 'Pre use' safety checks on vehicles, plant and equipment assessed as requiring such an inspection.	2			HTMs Estates Compliance					
16. We have procedures and arrangements for dealing with defects / breakdowns which occur during the course of work.	2			Estates Compliance Estates Helpdesk					
17. We have a system for identifying hazards associated with moving, locating and relocating plant / work equipment around site, including skips, containers etc.	2			Estates Compliance Estates Helpdesk					
18. We have arrangements for routinely inspecting plant and equipment in accordance with the PUWER regulations.	2			Estates Compliance PPMs					
19. We have arrangements with competent persons to perform statutory inspections of plant and equipment i.e. in accordance with the LOLER and PSSR Regulations.	2			Estates Compliance Insurance inspections carried out by assessors					
20. We have designed and constructed our site to take into account traffic and pedestrian movements and we have controls in place to ensure each user has a safe route around site.	2			Estates Compliance Specific Risk Assessments					

21. We have arrangements for performing routine site inspections which includes traffic management and behavioural safety.	2			Estates Compliance Grounds Maintenance Checks Incident reporting/RA's				
22. We have procedures for maintaining good housekeeping standards to minimise the risk of slips and trips.	2			H&S Policy Slips Trips Falls SOP Incident Reporting G4S associated process and policy for management of spillages				
23. We have controls in place to reduce the risk of falls from height (e.g. into / from skips) by avoiding at height movements and having a system of work that does not require access at height.	2			Slips Trips Falls SOP H&S Policy Ladder Training				
24. We have a system for identifying Manual Handling hazards, assessing risks and deciding how they can be eliminated or controlled, and all relevant employees have been trained accordingly.		1		General Risk Assessments Generic Risk Assessments M&L Handling Training OLM Training Records Cascade Training System Manual and Load Handling Equipment SOPS MH Report 2016 Exec's Paper Jan & March 2017	No load handling practical training sessions No lead for training or expert knowledge for MH No standardised equipment across Trust	*Trust to review options for access to, sharing services or employing MH Trainer Procurement Project re: standardising equipment (CIP opportunity) Utilise BORIS safety software*	*TB/JA/CMcG/GD*	
25. We have arrangements for ensuring employees are made aware of (and are provided with) the personal protective equipment which has been assessed as being required	2			Mandatory Training IPC Policy H&S Policy Safer Use of Sharps Policy Local Induction				

for a particular work activity.								
26. We have ensured that welfare facilities provided are suitable and sufficient to the work environment and those who will be required to use them i.e. staff, visitors, contractors.	2			H&S Policy Facilities Management				
PLANNING AND IMPLEMENTING SCORES	40	5						
TOTAL SCORE (Maximum = 52)	45							
For advice on planning and implementing see Chapter 4 of HSG65 and page 7 of IND275 *http://www.hse.gov.uk/simple-health-safety/manage.htm* *http://www.hse.gov.uk/simple-health-safety/workplace.htm* *http://www.hse.gov.uk/simple-health-safety/firstaid.htm* *http://www.hse.gov.uk/work-equipment-machinery/index.htm*								

MEASURING PERFORMANCE	Fully met (Score 2)	Partially met (Score 1)	Not met at all (Score 0)	Evidence	Gap	Action/Recommendation	Action by Whom	Completion Date
1. We have arrangements for monitoring progress with the implementation of our health and safety improvement plans and for measuring the extent to which the targets and objectives set under those plans have been achieved.			0			Create formal process Utilise BORIS	*TB*	
2. We have arrangements for active monitoring (i.e. checking) to ensure that our control measures are working properly, our health and safety rules and procedures are being followed and the health and safety	2			Annual H&S Report Regular review of incidents Quarterly SEE Report Annual Workplace Audits				

standards we have set for ourselves are being met.								
3. We have arrangements for reporting and investigating accidents, incidents, near misses and hazardous situations.	2			Annual H&S Report Regular review of incidents OLM Training Records Risk Assessment Risk Assessment & Incident Reporting Policy H&S Policy Sharps Policy COSHH SOP CAS Policy & Procedure				
4. Where the arrangements in 2 and 3 above show that controls have not worked properly, our health and safety rules or procedures have not been followed correctly or our safety standards have not been met we have systems to identify the reasons why performance was substandard and where necessary we use disciplinary procedures.		1		Management of incident reporting Ulysses	Not tested Not assured	*Audits to be undertaken and the action plan updated from findings* *Development of BORIS safety software system will improve compliance reporting*	*TB*	
5. We have arrangements for analysing the causes of any potentially serious events so as to identify the underlying root causes including causes arising from shortcomings in our safety management system and safety culture.	2			SOP for Managing Serious Incidents RCA Ulysses				
6. We have arrangements for measuring customer satisfaction in relation to safety of the products, services and activities we provide.	2			Family & Friends Survey PALS Complaints				

7. We have arrangements to ensure supervisors continue to check that information, instruction and training has been fully understood by staff and continues to be taken on and used.	2			Annual Workplace Audit and risk assessment reviews				
MEASURING PERFORMANCE SCORES	10	1						
TOTAL SCORE (Maximum = 14)	11							
For advice on measuring performance see Chapter 5 of HSG65 and page 9 of INDG275								

AUDITING & REVIEWING PERFORMANCE	**Fully met (Score 2)**	**Partially met (Score 1)**	**Not met at all (Score 0)**	**Evidence**	**Gap**	**Action/Recommendation**	**Action by Whom**	**Completion Date**
1. We have regular audits of our safety management system carried out by competent external auditors or competent auditors employed by our company who are independent of the department they are auditing.			0			*Ensure H&S safety management system is added to Trust round of external audits*	*IH*	
2. We use the information from performance monitoring and audits to review the operation of our safety management system and our safety performance.			0			*As 1*	*TB*	
3. We regularly review how well we have met the objectives in our health and safety improvement plans and whether we have met them in the agreed timescales.		1		Annual H&S Report Quarterly SEE Report	Capacity Software	*Utilise BORIS safety software system*	*TB*	

4. We analyse the information from performance measurement and use it to identify future improvement targets and to identify particular causes of accident, ill health or poor control of risk, to target for future risk reduction effort.		1		Annual H&S Report Quarterly SEE Report	Capacity Software	*Utilise BORIS safety software system*	*TB*	
5. We formally review our risk assessments annually and as required by certain events i.e. changes in operation, site layout, new purchases, and new developments or following an accident or incident on site.		1		Annual H&S Report Regular review of incidents	Capacity Software	*Utilise BORIS safety software system*	*TB*	
6. We analyse the information from customer safety breaches and use it to identify future improvement targets and to identify particular causes of accidents, near misses to target for future risk reduction effort.	2			Incident Management SOP for Managing Serious Incidents RCA Ulysses				
7. We analyse the information from plant and equipment breakdown / maintenance records to identify patterns of deterioration (cause analysis).	2			Annual service reports				
8. We periodically review the site layout to take account of changes in work activities, traffic type, volume and circulation.	2			On-going review				
AUDITING & REVIEWING PERFORMANCE SCORES	6	3						
TOTAL SCORE (Maximum = 16)	9							
For advice on auditing and reviewing see Chapter 6 of HSG65 and page 10 of INDG275								

Results

SECTION HEADING	Possible points	Actual points	% score	Comments and actions
Policy	14	11	78.5%	
Organising control	8	6	75%	
Organising communication	14	9	64%	
Organising co-operation	8	4	50%	
Organising competence	14	10	72%	
Planning and implementing	52	45	86%	
Measuring performance	14	11	78%	
Auditing and reviewing	16	9	56%	
Total points/overall	**140**	105	75%	
Date exercise carried out	**15/02/2017**			**Date to repeat exercise**

Appendix 2

HSE Business Plan 2017/18

Foreword

Great Britain has a health and safety record we can all be proud of. We are one of the safest places in the world to work in. Nonetheless, the plateaus we see in our health and safety statistics are also a stark reminder of the challenges we face in continuing to improve Britain's performance while we adapt to the rapidly changing world around us.

The benefits of continual improvement are substantial: for workers a healthier and safer workplace; for businesses, productivity and innovation; and for the wider economy reducing the £14 billion impact of work-related injuries and ill health, together with enabling the growth opportunities that come with creating a more attractive place to do business.

This plan outlines what HSE will deliver in 2017/18. It does not attempt to capture all that we do. Instead it highlights specific priorities, within an overall framework that reinforces our ongoing commitment to:

- leading and engaging those who undertake or influence health and safety – capitalising on the enthusiasm and collaboration we have been delighted to see since launching Helping Great Britain work well. This involves using modern communication and technology to change behaviours, and continuing to support our activities through robust science and evidence.
- ensuring the regulatory framework remains effective. This includes making sure that we are delivering the government's regulatory agenda and supporting the UK's exit from the European Union;
- securing effective risk management and control through a variety of regulatory tools that involve direct interactions with dutyholders. This includes our licensing activities, sustaining existing levels of intelligence-led inspections and investigating incidents, with people being held to account for their failures through firm, but fair, enforcement of the law;
- reducing the likelihood of low-frequency, high-impact catastrophic incidents and the potential for extensive harm to workers and the public. Major hazard dutyholders are subject to a level of regulatory scrutiny proportionate to their risks and performance. This includes considering leadership, workforce competence and engagement, and maintenance of asset integrity.

This plan takes forward key elements from HSE's overall strategy Helping Great Britain work well, in particular:

- Emphasising ill health as we build on the recent launch of our Health and Work programme, with its focus on respiratory diseases, musculoskeletal disorders, and occupational stress and related mental health issues.
- Reinforcing proportionate approaches by setting expected standards, targeting our intelligence-led interventions, and ensuring any enforcement action takes into account the seriousness of risks. For businesses, and in particular for SMEs, this is seen in the beginning of our work on 'blue tape' (where businesses place excessive burdens on each other).
- Ensuring value for money for the taxpayer by reducing our reliance on government funding while continuing to improve our efficiency and effectiveness.
- Bringing together the breadth of capability and expertise across HSE, and benefiting from effective collaboration with the many other people and organisations that have a stake in improving health and safety in the workplace.

We look forward to your encouragement and contribution as we collectively Help Great Britain work well.

Richard Judge
Chief Executive

Martin Temple
Chair

Contents

Lead and engage with others to improve workplace health and safety

Background

HSE engages with all those who undertake, or influence, workplace occupational health and safety across Great Britain. Through leadership and acting as a catalyst we seek to achieve behaviour change that helps our strategy, Helping Great Britain work well. It highlights priority themes which continue to be reflected in our actions.

Our emphasis is on:

- focused **engagement and collaboration** across networks of individuals and organisations with a strong interest in improving work-related health and safety. This includes employees and employers, trade unions, industry associations, professional institutions and third-sector bodies, alongside other government agencies and regulators;
- specific **campaign activity** to achieve tangible improvements in awareness and action on the key issues and themes set out in our strategies;
- providing **guidance and support materials** which are accessible and tailored to the circumstances of the users;
- developing **science and evidence** to support our regulatory activities, and providing access to our know-how, specialist facilities and research to enable improved occupational health and safety performance.

What did we deliver in 2016/17?

- Developed and began to engage on our Health and Work strategy and sector plans – which set the basis for our regulatory activities over the next few years
- Launched the Helping Great Britain work well strategy which recognised over 100 commitments made by over 80 industry, trade union and other groups to improve health and safety in their workplaces and industries
- Contributed to the publication of a plan to coordinate action by partners in the health and safety system in Scotland
- Identified 11 partners to engage with on shared research projects to support Helping GB work well

Our priorities for 2017/18

- Establish and begin delivery of a comprehensive three-year **Health and Work programme** to reduce levels of work-related stress, musculoskeletal disorders and occupational lung disease
- Use our knowledge of **small and medium-sized enterprises (SMEs)** and their risk profile to target groups where we can have the most impact, introducing **new approaches** to enable them to manage health and safety sensibly and proportionately
- Further embed a **broader ownership** of health and safety through accelerating our Helping Great Britain work well campaign, and engage with relevant stakeholders to obtain buy-in to the priorities in our **sector plans**
- Better enable employers/dutyholders to understand how to manage health and safety risks through an enhanced website and more **user-focused content**
- Reinforce our links with other regulators, with a specific focus on **sharing technical expertise** and enhancing our regulatory intelligence networks through use of modern data analytics

Our actions will include:	Our key deliverables/milestones will include	Due
Establishing a comprehensive three-year Health and Work programme		
Use feedback from our stakeholders to refine proposals and complete the external engagement on Heath and Work delivery plans	Publish Health and Work delivery plans as part of a national conference	Q2
Identify the evidence needs in support of the Health and Work programme	Agree a supporting science and evidence programme with opportunities for shared research	Q2
Customise the stress management standards approach in healthcare, education and prisons to drive greater adoption and ownership	Produce an interim report on progress to the HSE Board	Q3
Create a partnership across existing stakeholder groups for coordinating activity and direction on occupational lung disease	Body in place	Q2
Developing new approaches for SMEs		
Develop an insight-led programme of activity setting out HSE's future work on SMEs	Present progress to date and programme plan to the HSE Board	Q4
Continue development of insight into construction SMEs' understanding, management and control of risk, understanding how to better influence appropriate actions and shape a range of interventions	Complete research and present the findings and associated recommendations to the HSE Board	Q4
Embedding a broader ownership of health and safety		
Sustain a focus on engaging others through HGBWW, and explore the merits of an accreditation offer that allows significant contributions to be recognised	Deliver a stakeholder event linked to HGBWW	Q3
	Provide recommendations on the merits of an accreditation offer to the Management Board	Q3
Use feedback from stakeholders gained through various channels including regional face-to-face events to refine our draft sector plans	Publish final sector plans as part of a national conference	Q2
Developing user-focused content		
Develop a design for HSE's new website	Finalise a design proposal tested with target users for refreshing and renewing HSE web content	Q4
Sharing technical expertise		
Develop pilot data-sharing platform with other government departments	Complete externally funded pilot projects with two other government departments to assess options and viability for taking this further	Q2

Provide an effective regulatory framework

Background

We will maintain our oversight of the core domestic regulatory regime and we expect it to make a significant contribution to the government's deregulatory agenda and Business Improvement Target.

We will contribute to the government work on the UK's exit from the European Union and on the sectoral cross-cutting Red Tape Reviews and Regulatory Futures Review as appropriate.

We will also be looking at how we can tackle the challenges of blue tape where the bureaucratic demands placed by businesses on each other can be disproportionate to the risks faced. This work is, however, subject to other demands.

What did we deliver in 2016/17?

- Continued to maintain and improve the domestic regulatory framework including:
  - completing a post-implementation review of the Control of Asbestos Regulations 2012
  - implementing the Electromagnetic Fields Directive with the Control of Electromagnetic Fields at Work Regulations 2016
  - replacing the Dangerous Substances in Harbour Areas Regulations with shorter, simpler regulations
- Agreed a memorandum of understanding with the Health Inspectorate Wales
- Consulted on proposals to place more emphasis on risk control and less on written assessment. This has provided insight for a wider review to look at how well HSE guidance focuses on simple, proportionate messages about risk management as well as improving the user journey

Our priorities for 2017/18

- Manage and, where necessary, **update or simplify our regulatory framework** and approach in line with government policy
- Contribute to the government work on the UK's **exit from the European Union**, including preparing for any necessary changes to the chemicals regime
- Begin to develop the evidence-base and outline proposals that will address **blue tape** issues (where businesses and others place excessive and disproportionate health and safety burdens upon each other)

Our actions will include:	Our key deliverables/milestones will include	Due
Maintaining the regulatory framework		
Undertake review of the Adventure Activities Licensing Authority (AALA)	Make recommendations to the HSE Board for subsequent implementation	Q2
Amend the Gas Safety (Installation and Use) Regulations 1998 to introduce flexibility in the timings of annual gas safety checks and support the innovation agenda	Make proposals to the HSE Board for onward recommendation to the Minister	Q3
Implement the recommendations of the post-implementation review of the Control of Asbestos Regulations 2012	Implement proposed legal changes	Q4
Implement the occupational health and safety parts of the Basic Safety Standards Directive	Make proposals to the HSE Board for onward recommendation to the Minister	Q3
Report HSE's progress to support the Business Improvement Target	Publish report on HSE website	Q4
Conduct informal consultation to support the review and simplification of occupational health and safety regulations in chemicals without reducing standards	Make recommendations for future changes and subsequent implementation to the HSE Board	Q4
Developing the evidence base and proposals to address blue tape issues		
Begin to develop the evidence base relating to blue tape	Summarise progress, present evidence and outline proposals for future activities to the HSE Board	Q4

Secure effective management and control of risk

Background

HSE's primary focus is preventing harm to workers, but our regulatory interest extends to cover the impact of work activities on the general public, consumers and the environment.

We use a variety of evidence-based interventions to secure effective management and control of risk from a wide range of common hazards.

Permissioning and licensing regimes ensure high levels of protection and the proficiency of businesses in high-hazard activities such as asbestos removal, gas safety and explosives – and the safe use of over 6000 approved products for use as pesticides and biocides in Great Britain.

We carry out around 20 000 workplace inspections, investigate over 6000 incidents and look into over 10 000 health and safety concerns people report to us. We also collaborate extensively with other regulators, such as local authorities.

Where risks are not being effectively managed, we provide advice and take fair and firm enforcement action to secure proportionate and sensible improvements. When necessary, we hold to account those who fail to meet their obligations to protect people from harm.

This approach supports growth and a level playing field for those who invest to manage the risks they create and deters those that do not meet their obligations or deliberately break the law.

What did we deliver in 2016/17?

- Began to develop our approach to introduce digitally enabled licensing services
- Focusing on risk reduction, we secured improvements in health and safety management in more premises than in 2015/16. We took action to control serious risk in over 9000 of our proactive inspection visits (2015/16: c8300)
- Continued to improve the timeliness of our investigations, with 80% of fatal investigations completed within 12 months of HSE assuming primacy (2015/16: 70%)

Our priorities for 2017/18

- Deliver around 20 000 proactive inspections to prevent harm, with increasing use of campaigns that focus these inspections on specific issues and activities found in high-risk industries, including a **sustained focus on health risks**
- Sustain improvements to the **timely completion of investigations** and explore, in collaboration with others, further actions which will positively impact on pace
- Improve how we share learning and influence dutyholders to **amplify the impact** of our interventions and enforcement action
- Further improve the **timeliness of decisions on applications** for authorisation of biocides and pesticides
- Provide support to UK-based companies, particularly SMEs, with **REACH[1] 2018 registration** responsibilities
- Begin to **digitise** the provision of our services, starting with radiological protection registration and licensing, and asbestos licensing

[1] Registration, evaluation, authorisation and restriction of chemicals

Our actions will include:	Our key deliverables/milestones will include	Due
Sustaining inspection focus on health and specific higher-risk issues and activities		
Undertake a targeted programme of approximately 20 000 proactive inspections, half of which will be through major campaigns that address priority issues within high-risk industries identified in sector plans and in our Health and Work strategy	As part of the targeted programme we will deliver seven major inspection campaigns (each with at least 500 inspections) targeting: ● Agriculture ● Construction refurbishment (2) ● Manufacturing: Fabricated metal ● Manufacturing: Food ● Waste and recycling ● Manufacturing: Woodworking	Q4
Assure the ongoing effectiveness of the asbestos licensing regime	Up to 1000 targeted inspections of asbestos removal projects to evaluate licensee performance	Q4
Sustained improvements to the timely completion of investigations		
Sustain focus on the timeliness of investigations	80% of fatal investigations completed within 12 months of HSE assuming primacy	-
	90% of non-fatal investigations completed within 12 months of the incident	-
Amplifying our impact		
Develop and test the harnessing of prosecution and selected inspection activity to create targeted campaigns to prompt industry behaviour change	Pilot a programme of communication activity to influence a wider range of dutyholders by learning from action taken through HSE's interventions	Q2
	Evaluate impact of new programme	Q4
Improving the timeliness of biocides and pesticides decisions		
Sustain focus on improving the proportion of decisions made within legislative deadlines	90% of pesticide evaluations completed within the legislative deadlines	-
	80% of biocide evaluations completed within the legislative deadlines	-
Supporting SMEs with REACH 2018 registration responsibilities		
As the UK REACH Competent Authority, contribute to the Defra-led plan to maximise awareness of, and compliance with, duties to register substances under REACH 2018	All relevant businesses contacted to identify if they require further support to register by 31 May 2018	Q4
Beginning to digitally enable our services		
Design a new, user-focused digital service, for asbestos licensing and radiological protection registration and licensing	Deliver a new digital platform for radiological protection registration and licensing	Q3
	Design a new digital platform, for asbestos licensing	Q3

Reduce the likelihood of low-frequency, high-impact catastrophic incidents

Background

Great Britain has many highly specialised, strategically important industries which are essential to the country's economy and social infrastructure, but can potentially cause great harm to their workers, the environment and the public if not properly managed.

These sectors include offshore oil, gas and renewable energy; onshore chemical industry; production and storage of explosives; mining; and the bioeconomy. In all these sectors, a single incident could have catastrophic consequences and has the potential to undermine whole sectors by eroding the public's trust and acceptance of complex, high-hazard activities, especially those near to communities.

There is major change underway in these sectors:

- In the energy sector, some older offshore oilfields are coming to the end of their lifespan, and decommissioning of wells is gathering pace while fresh reserves continue to be discovered and exploited, requiring new installations and, in some cases, new technologies.
- Onshore exploitation of shale gas is still in its infancy, and likely to increase in coming years.
- Cybersecurity is becoming a bigger issue across all sectors, and the bioeconomy is forecast to grow rapidly.

Effective leadership is essential to ensure risks are adequately controlled in all these industries. Major hazard dutyholders will be subject to a level of regulatory scrutiny that is proportionate to their risks and performance, including scrutiny of safety leadership within the organisation, and maintenance of asset integrity.

HSE will continue to adapt to effectively regulate these sectors, through a combination of assessment, licensing specific higher-risk activities, and planned inspections and investigations. These interventions are designed to provide assurance that the risks associated with major hazards are being properly managed.

What did we deliver in 2016/17?

- Completed a targeted programme of proactive inspections and face-to-face interventions at major hazard sites on and offshore to secure risk reduction
- Commenced publication of offshore topic performance scores awarded as a result of our inspection activity
- Completed the reassessment of all offshore transitional safety cases and COMAH[2] 2015 safety cases within the required timescales
- With the COMAH Strategic Forum, developed an updated strategy for the chemical processing, refining, bulk storage and distribution sector

Our priorities for 2017/18

- Work with stakeholders, including trade associations, on **strengthening leadership and worker engagement** across all the major hazard sectors
- Participate in the UK's agenda on dealing with **security risks**, including cybersecurity
- Develop our regulatory approaches to **decommissioning and ageing infrastructure**, and to ensure the **integrity of new assets and emerging technologies**
- Deliver targeted interventions focusing on the control of high-consequence risks from **cooling towers, fairgrounds and major construction projects**

[2] Control of Major Accident Hazards

Our actions will include:	Our key deliverables/milestones will include	Due
Strengthening leadership and worker engagement		
Carry out Maintaining Safe Operations[3] audits of seven dutyholders at their offshore installations	Conduct in-depth inspection and report our opinion to the dutyholders involved at seven sites	Q4
	Feedback key findings from the programme to industry leaders	Q4
Engage with senior industry leaders to implement and promote a risk reduction action plan across whole offshore renewables sector	Host an offshore renewables industry leadership event, emphasising the key role of senior leaders	Q3
Work with senior leaders in high-hazard industries to clarify the expected benchmark for good leadership and the key observable attributes of an organisation with good leadership	With the COMAH strategic forum, recommend benchmarks for effective leadership in high-hazard industries	Q4
Participating in the UK's agenda on dealing with security risks, including cybersecurity		
Develop a strategy for cybersecurity in the chemicals sector	Obtain HSE Board approval for the strategy	Q2
	Deliver a joint conference for the major hazard industries with Chemical Industry Association	Q4
Focusing on decommissioning and ageing infrastructure, and the integrity of new assets and emerging technologies		
Develop our intervention approaches for key changes and advances in the bioeconomy	Agree with key stakeholders the UK protocol for the assessment of facilities handling the polio virus in line with the World Health Organisation global programme	Q2
Review existing legislation and guidance relating to offshore decommissioning	Present findings and recommendations arising from review to the HSE Board	Q3
Controlling high-consequence risks from cooling towers, fairgrounds and major construction projects		
Undertake a programme of return visits to poorly performing dutyholders to ensure that legionella risks continue to be effectively managed	Programme of visits completed	Q4
Deliver a targeted programme of inspections of fairground rides with known safety issues at fixed parks and travelling fairs	Programme of visits completed	Q4
Early and strategic interventions with clients, designers and contractors involved with major construction projects to assure compliance with CDM 2015 and reduce the likelihood of catastrophic incidents	Specific engagement and intervention plans agreed for each project to test key risk management and control systems	Q1
	Project-specific intervention plans implemented through targeted inspection during the construction phase	Q4

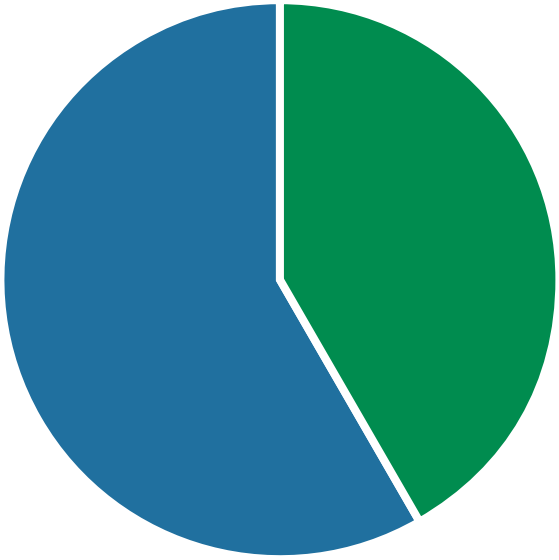
[3] This activity will form an opinion of their ability to ensure the sustainable organisational capability, with a particular focus on leadership, competence and workforce engagement.

Financial outlook for 2017/18

The Spending Review and Autumn Statement set out the government's plans to ensure Great Britain's long-term economic security. As part of that Spending Review, HSE, like many other public bodies, will receive reduced government funding over the spending review period.

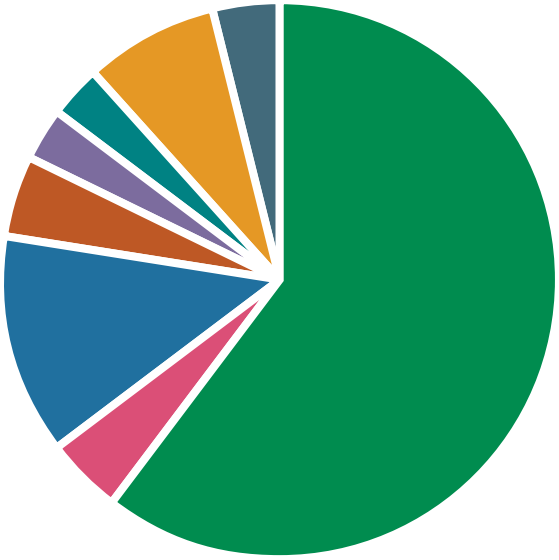
	2016/17 £million	**2017/18 £million**	2018/19 £million	2019/20 £million
Forecast taxpayer-funded income to HSE	140.5	**135.6**	128.4	128.4

HSE Funding 2017/18 (£232 million)



- Income **£96 million**
- Taxpayer funded **£136 million**

HSE Expenditure 2017/18 (£232 million)



- Staff costs **£141 million**
- Staff related **£10 million**
- Estates **£30 million**
- IS/IT **£11 million**
- Technical support **£6 million**
- Depreciation **£7 million**
- Other **£18 million**
- Capital **£9 million**

Delivering efficiently and effectively

In responding to this financial challenge, HSE will seek to maintain current levels of its core regulatory activities including permissioning, inspection, investigation and enforcement.

We are committed to ensuring value for money for the taxpayer by reducing our reliance on government funding over the life of the Parliament, while continuing to improve the efficiency and effectiveness of our delivery. We will also sustain HSE's position as a high-performing regulator that enables improvements in health and safety outcomes whilst being resilient and responsive to dynamic external influences in which we operate.

Our actions to deliver these commitments can be described in terms of the following themes:

Sustaining regulatory excellence

HSE is founded on regulatory excellence, something we are determined to protect and enhance. The principles have stood the test of time, driving dutyholders to improve their risk management to create safer, healthier workplaces.

We will avoid complacency through investment in our core regulatory capabilities, policies and increasing number of intelligent regulatory tools, while introducing the skills and approaches that keep us modern, relevant and responsive in a changing world. We will work even more closely with other regulators, including as part of the Regulatory Futures Review where appropriate, to maximise the impact of our activities.

Growing commercial activities

We will capitalise on our know-how and specialist facilities in the UK and internationally with a specific focus on shared research in conjunction with partners.

Alongside the financial benefit, commercial activities enable us to learn from approaches taken elsewhere, and provide development opportunities for individuals. Sharing our expertise increasing through a digital approach supports enhanced standards and can improve dutyholder performance.

Investing in people and capability

We will continue to build positive energy, making HSE a great, diverse organisation where people are proud to work as part of 'You Can with HSE', and we aim to become a Disability Confident[3] employer in 2017/18.

We will continue to increase engagement, improve learning and development, and invest in our leadership capability. We will also sustain the strong regulatory, policy and scientific capabilities that in combination have been at the core of HSE's success over the last 40 years.

Driving operational efficiency and effectiveness

We will continue to drive operational efficiency improvements across HSE through better introduction and use of technology, simpler processes and a relentless focus on value for money.

Simplifying and streamlining our business processes, and increasing the use of digital techniques to modernise how we interact with dutyholders and the public, will be key programmes of investment that will create more fulfilling roles.

We will continue to focus on delivering cash savings through improved procurement and contract management in areas including office supplies, storage, logistics and distribution. In addition, our estates strategy will see us further rationalising our overall use of space, sharing government facilities and securing lower cost leases.

[3] www/gov.uk/government/collections/disability-confident-campaign

Further information

For information about health and safety, visit www.hse.gov.uk. You can view HSE guidance online and order priced publications from the website. HSE priced publications are also available from bookshops.

This plan is available at: www.hse.gov.uk/aboutus/strategiesandplans/businessplans

Published by the Health and Safety Executive 03/17

Agenda Item	2017/248(ii)

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Quality Strategy 2017-2020**
DATE OF MEETING:	Friday, 01 September 2017
ACTION REQUIRED	**For Approval**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Colin Reid, Trust Secretary
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☐ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☒ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS*** ☒

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☒	**4.** NHS Constitution ☒ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**
FREEDOM OF INFORMATION (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 approve the revised Quality Strategy 2017-2020***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	**Governance and Clinical Assurance Committee**
	Date of meeting	Monday, 17 July 2017

Executive Summary

On 6 June 2017 the Board approved the Quality Strategy 2017-2020 following a recommendation from its assurance committee Governance and Clinical assurance Committee (GACA).

Following approval, the Medical Director received a number of comments from Senior Clinicians seeking revision to the Strategy with regard to the content in the sections of the Strategy headed ***'How will we know we have been successful?'*** The revisions related to replacing all references to ***'year on year reductions'*** with more realistic descriptions for 'reductions'.

Following review by GACA at its meeting on 17 July 2017, GACA approved the revisions to the Quality Strategy and were advised that the regulators had been informed of the amendments and were supportive of the amendments.

Recommendation:

The Board is asked to approve the revised Quality Strategy 2017-2020 attached.

Quality Strategy: 2017-2020

Liverpool Women's NHS Foundation Trust

Contents

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
🡻 Reduction in medication incidents resulting in harm
🡹 Increase in patient safety incident reporting
🡹 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
⬇ 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
↓ Reduction in unexpected returns to theatre
↓ Reduction in unexpected readmissions to hospital
↓ 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
↑ 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

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

☺ Mortality rates for very low birthweight babies to be comparable to the best other neonatal units nationally and internationally

☺ 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
↑ 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
↑ Increase in positive feedback from leadership programme reflection sessions
↑ Increase in number of visits to web page
↓ Reduction in sickness absence
↑ 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
↑ 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
↓ Decrease in formal complaints
↓ Decrease in the time taken to respond to formal complaints
↓ Decrease against the thematic issue identified in each annual work-plan (e.g. triage access)
↑ 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	2017/249

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	Performance Dashboard Month 4
DATE OF MEETING:	September 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Jeff Johnston, Director of Operations
AUTHOR(S):	Jeff Johnston, Director of Operations
STRATEGIC OBJECTIVES:	***Which Objective(s)?***
	1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒
	2. To be ambitious and *efficient* and make the best use of available resource ☒
	3. To deliver *safe* services ☒
	4. To participate in high quality research and to deliver the most *effective* Outcomes ☐
	5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***
	1. *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒
	2. *The Trust is not financially sustainable beyond the current financial year* ☐
	3. *Failure to deliver the annual financial plan* ☐
	4. *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐
	5. *Ineffective understanding and learning following significant events* ☒
	6. *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒
	7. *Inability to deliver the best clinical outcomes for patients* ☒
	8. *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?***
	SAFE- *People are protected from abuse and harm* ☒
	EFFECTIVE *- people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒
	CARING *- the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐
	RESPONSIVE – *the services meet people's needs.* ☐
	WELL-LED *- the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒
	ALL DOMAINS ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: Click here to enter text.
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**	*Choose an item.* Or type here if not on list: *Click here to enter text.*
	Date of meeting	*Click here to enter a date.*

1. Introduction

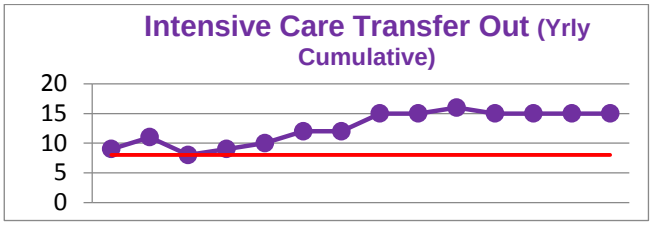
The Trust Board performance dashboard is attached in appendix 1 below.

2. Performance

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

2.1 Safe Services – Intensive Care Transfer Out

All patients transferred out of the hospital for intensive care are review by the Trust HDU Group and consideration given to the care given. The actual number in the indicator is the cumulative rolling for a year which equates to 15 patients.



Intensive Care Transfer Out (Yrly Cumulative)	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Actual	9	11	8	9	10	12	12	15	15	16	15	15	15	15
Target	8	8	8	8	8	8	8	8	8	8	8	8	8	8

2.2 All Cancers: 62 day wait for first treatment from urgent GP referral for suspect cancer (before re- allocation)

In July, when the cancer data base was finalised for June the reported position is 76.19%. This is due to three patients breaching the target as a result of late referrals from other Trusts. The after re-allocation position takes the Trust back to a compliant 88.89% finalised report.

Full explanations have been provided to the Cancer Alliance, NHSE and the Clinical Commissioning Group.

3. Emerging concerns

Gynaecology activity is not achieving contracted plan and could have some impact on 18 weeks referral to treatment time, although there is no significant impact on these targets at the moment. The operational team are working through the issues and are in the process of producing a recovery plan.

4 Conclusion

The Trust is achieving its National access and A & E targets however an increased focus is required in terms of the national drive to improve Cancer 62 day targets.

5 Recommendation

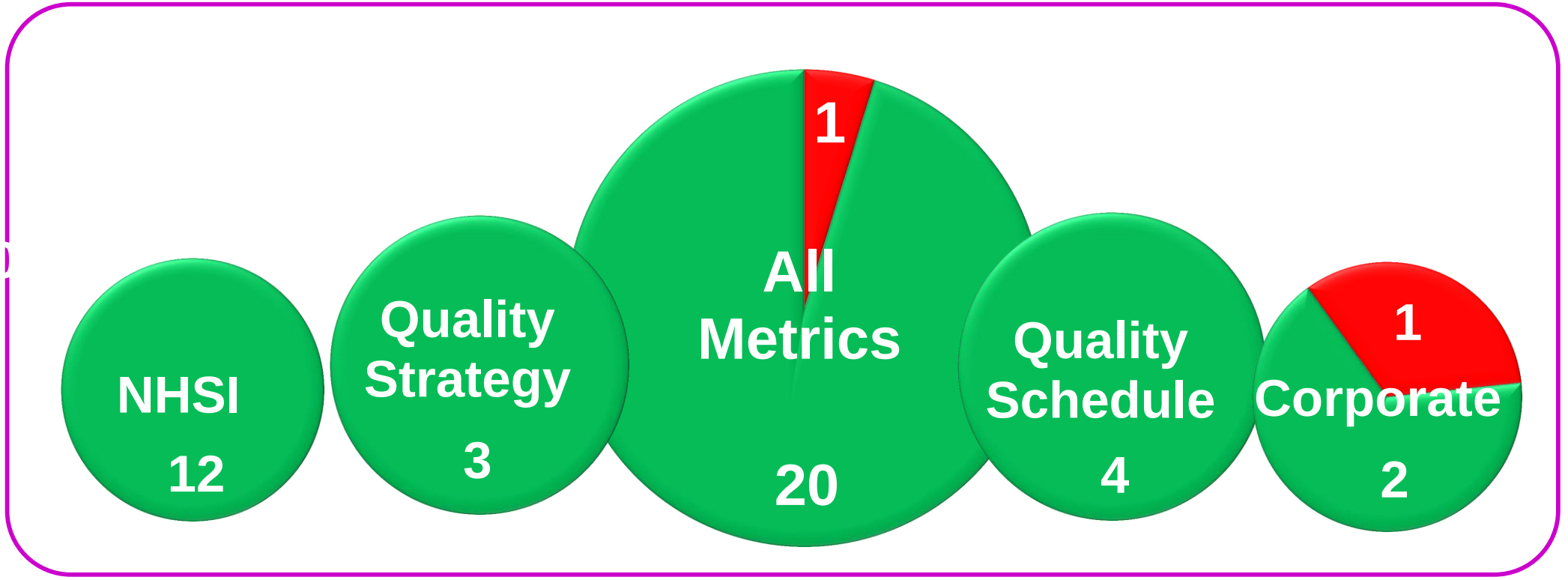
The Board note the content of the report

APPENDIX 1

Performance and Information Department
Performance Team

Liverpool Women's NHS Foundation Trust

Performance Report for Trust Board — Month 4 - July 2017



* HR Sickness is shown in both NHSI and Quality Schedule but only recorded once in the All Metrics pie chart. Also only showing once in the Workforce chart.

Liverpool Women's NHS Foundation Trust

NHS Improvement 2017/18 Month 4 - July 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	3	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	0	1		0											
Infection Control: MRSA	KPI105 (EAS4)		0	0	0	0		0											
Never Events	KPI181		0	1	0	0		0											
NHSE / NHSI Safety Alerts Outstanding	KPI193		0	0	0	0		0											
Infection Control: Clostridium Difficile - infection rate	KPI320		TBC	0	0	0		0											
Mortality Rates: Hospital Standardised Mortality Rates (HSMR) - weekend (1 Month Behind)	KPI321		TBC	0	0	0		0											
Mortality Rates: Hospital Standardised Mortality Rates (HSMR) - weekday (1 Month behind)	KPI321		TBC	0	0	0		0											
Mortality Rates: Summary Hospital Mortality Indicator	KPI322		TBC	0	0	0		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%	5.17%	4.56%		4.05%											

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%	95.31%	94.83%	94.90%	94.25%											
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (**Before re-allocation**) **Provisional Position**	KPI031 (EB12)	Chris McGhee	>= 85%	100.00%	85.00%	87.50%	91.38%	85.71%											
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (**Before re-allocation**) **Final Reported Position**	KPI031 (EB12)	Chris McGhee	>= 85%	100.00%	85.00%	76.19%	85.45%												
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (**After Re-allocation**) **Provisional Position**	KPI030 (EB12)	Chris McGhee	85%	89.47%	86.36%	87.50%	87.50%	85.71%											
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (**After Re-allocation**) **Final Reported Position**	KPI030 (EB12)	Chris McGhee	85%	87.50%	85.00%	88.89%	87.04%												
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	0.0	1.0	0.5	1.5	0.0											
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Percentage	KPI034 (EB14)	Chris McGhee	>= 90%	No Pts Applicable	100%	100%	100%	No Pts Applicable											
Complaints: Number Received	KPI038	Kevin Robinson	<= 15	10	9	5		5											

LWH Quality Schedule 2017/18 LWH Quality Schedule

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

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

Indicator Name	CCG 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
HR: Sickness Absence Rate	KPI_26			<= 4.5%	4.64%	5.17%	4.56%	4.05%								

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	0	0	0								
A&E: Total Time Spent in A&E 95th percentile	KPI012 (KPI_62)	Monthly	Sharon Owens	<= 240	235	231	220	221								
Friends & Family Test (Upper quartile will recommend)	KPI089	Monthly		>= 75%	97.5%	98.5%	85.2%	96.7%								

LWH Quality Strategy 2017/18 LWH Quality Strategy

To develop a well led, Capable, Motivated and Entrepreneurial WORKFORCE				Key: TBA = To Be Agreed. TBC = To Be Confirmed, TBD = To Be Determined, ID = In Development												
Indicator Name	**CCG 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**
Sickness & Absence Rate	KPI101			<= 4.5%	4.64%	5.17%	4.56%	4.0%								

To deliver SAFER services																
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**
Never Events	KPI181			0	1	0	0	0								
Mortality Rates: Summary Hospital Mortality Indicator	KPI322			TBA	0	0	0	0								

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**
Complaints: Number Received	KPI038			<= 15	10	9	5	5								

LWH Corporate 2017/18 Month 4 - July 2017

To deliver SAFER services															
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**
Deaths (All Live Births within 28 Days) All live births	**KPI168**		**< 6.1%**	**0.14%**	**0.38%**	**0.28%**	**0.15%**								
Deaths (All Live Births within 28 Days) Booked births	**KPI168**		**< 4.6%**	**0.15%**	**0.26%**	**0.29%**	**0.15%**								

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 per year (Rolling year)**	**15**	**15**	**15**	**15**								

Agenda Item	217/250

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Month 4 Finance Report**
DATE OF MEETING:	1st September
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Vanessa Harris, Director of Finance
AUTHOR(S):	Jenny Hannon, Deputy Director of Finance
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☐ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☐ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☒ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☐ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution **2.** Operational Plan **3.** NHS Compliance	☐ ☒ ☒	**4.** NHS Constitution **5.** Equality and Diversity ***6.*** Other: Click here to enter text.	☐ ☐
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 Month 4 Financial Position and Forecast Outturn***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		**Finance Performance and Business Development Committee**	
	Date of meeting		Tuesday, 29 August 2017	

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.

At Month 4 the Trust is slightly better than plan with an actual deficit of £0.196m against a deficit plan of £0.200m. Cumulatively the Trust is ahead of plan by £0.049m and is forecasting to deliver the full year control total.

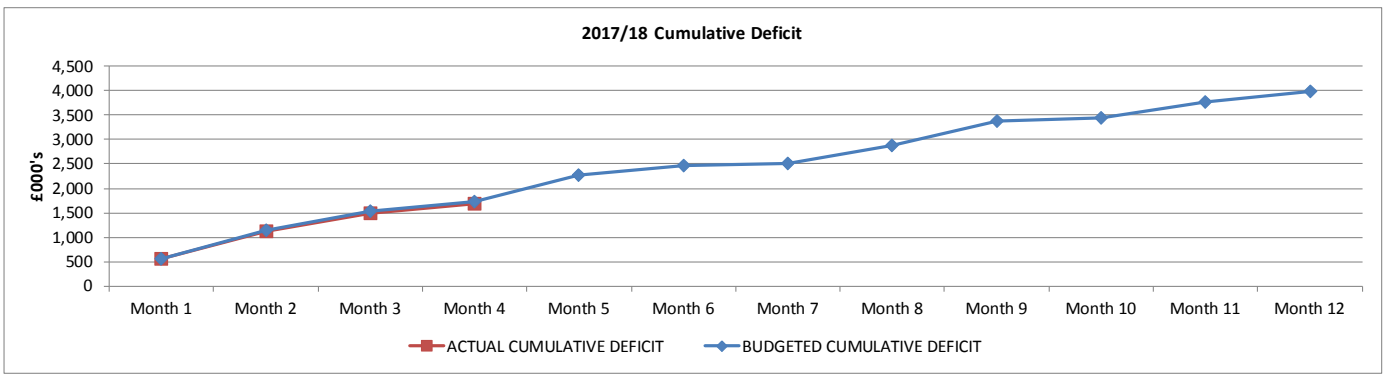
The Trust delivered a finance and use of resources' of 3 in month which is equivalent to plan.

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

Report

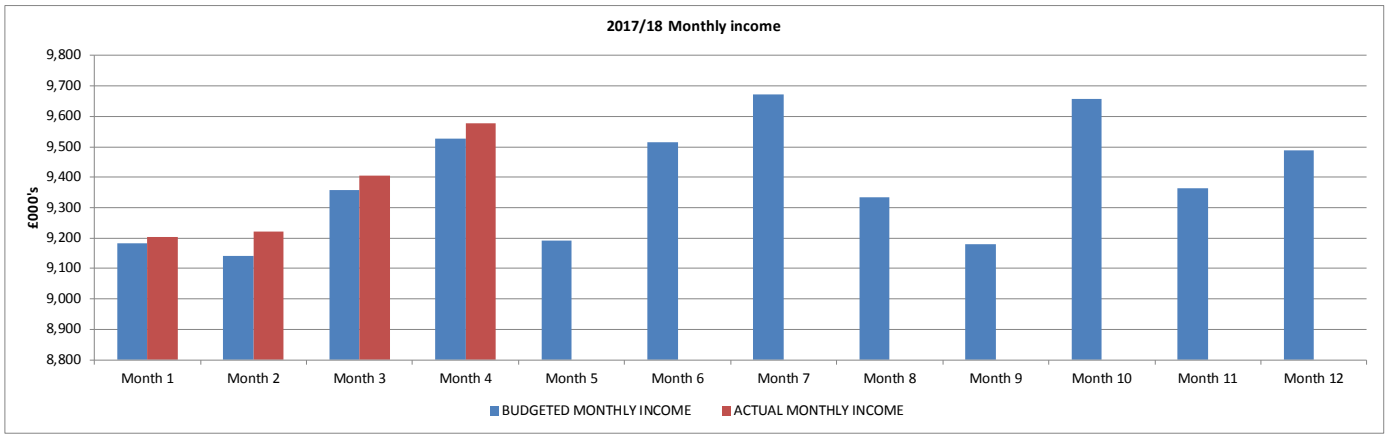
1. Month 4 2017/18 Summary Financial Position

The 2017/18 deficit is profiled below.



The Trust is achieving the planned deficit at Month 4.

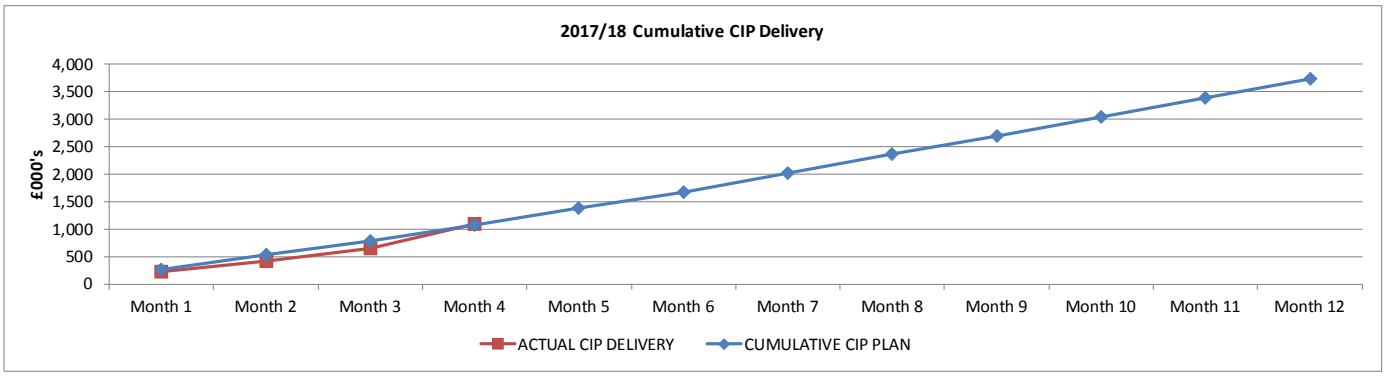
Despite a large proportion of income being under block contract with the Trust's main commissioners, there remains an element of payment by result (PbR) in the income plan. Within the financial plan the block is profiled to reflect expected activity levels in each month.



The CCG block payment for Month 4 was higher than what would have been received under PbR for the level of activity in that month. This arose across both general gynaecology and maternity, with activity levels in each below plan. Cumulatively the Trust continues to benefit from the block arrangement in 2017/18 and this remains under close scrutiny.

Pay expenditure was on plan overall. Non-pay expenditure exceeded budget by £0.07m largely as a result of slippage in non-pay CIP (pathology contract and estates) mitigated elsewhere.

CIP is profiled based on expected delivery across the financial year. Cumulatively the Trust is now slightly ahead of plan overall and forecasting to deliver the full £3.7m of CIP (with £0.7m on a non-recurrent basis). Some of the mitigation has arisen from over performance in other service areas, the formal virements and budget retractions in relation to this will take place for Month 5.



The detailed financial position is presented in appendix one.

2. Service summary overview

Maternity services are overall on plan in month and year to date. As noted at month 3, the service is currently forecasting an overspend on pay arising from additional recruitment in midwifery in response to

concerns raised within the service. The practice of recruiting midwives as a cohort as they complete their training (as for neonates) will be considered as part of 2018/19 budget setting.

Gynaecology and theatres together were favourable to budget, However, activity in general gynaecology was notably behind plan in month. Income was maintained as a result of the block arrangement and a detailed review of activity is under way.

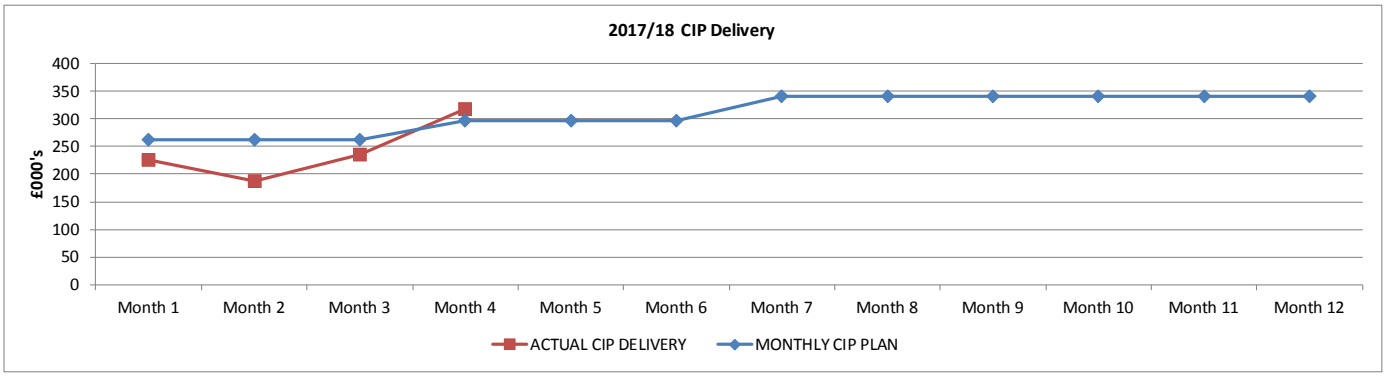
Neonates were again better than plan overall and the service is forecast to achieve slightly better than plan for the full year.

Hewitt Fertility Centre was slightly ahead of plan and is forecast to deliver its current contribution target.

Genetics are ahead of plan and are forecasting to over-perform, this is largely arising from medical and scientific vacancies which are due to be filled later in the year. This over-performance is supporting non-delivery of CIP on a non-recurrent basis.

3. Month 4 CIP Delivery

The Trust has an annual CIP target of £3.7m for 2017/18. Month 4 delivery was £0.318m against a £0.297m target.

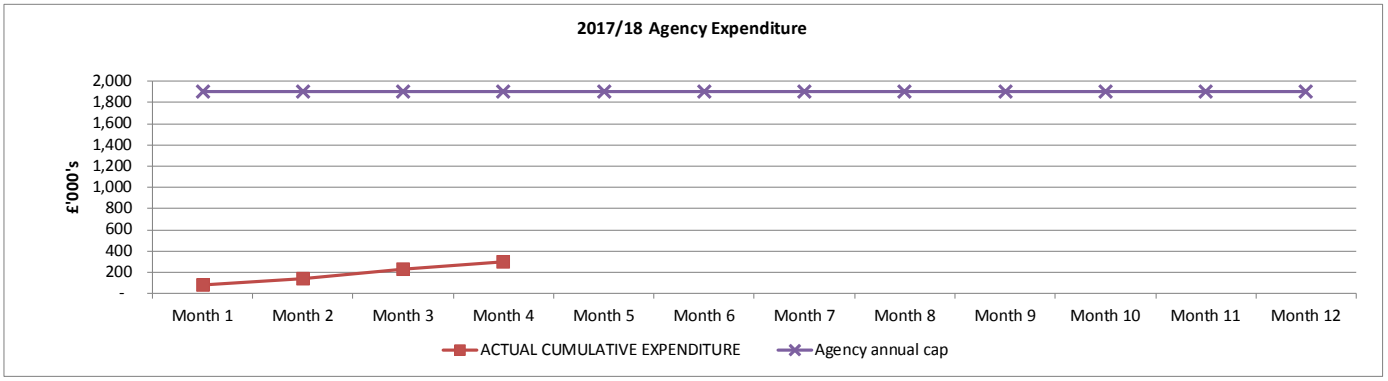


Cumulatively the Trust has delivered £1.085m of the £1.083 target at Month 4.

Scheme performance and recurrent delivery in both this and future financial years remains focus of the Trust's Turnaround and Transformation Committee.

4. Agency Spend

The annual agency cap set by NHSI for the Trust is £1.9m. In Month 4 the Trust incurred £0.072m of agency expenditure (cumulative £0.302m) and plans to remain within the cap for the financial year.



5. 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 4.

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.

6. BAF Risk

There are no changes proposed in relation to the BAF.

7. Conclusion & Recommendation

The Committee are asked to note the Month 4 financial position

Appendix 1 – Board pack

APPENDIX 1

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M4

YEAR ENDING 31 MARCH 2018

Contents

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	377	368	2,341	2,192
(b) PDC + Interest Payable + Loans Repaid	640	594	2,532	4,741
CSC Ratio = (a) / (b)	**0.59**	**0.62**	**0.92**	**0.46**
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	(3,006)	(2,619)	(2,598)	(3,212)
(b) Expenditure	36,835	37,045	110,277	110,765
(c) Daily Expenditure	307	309	306	308
Liquidity Ratio = (a) / (c)	**(9.8)**	**(8.5)**	**(8.5)**	**(10.4)**
NHSI LIQUIDITY SCORE	3	3	3	3
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)				
I&E MARGIN				
Deficit (Adjusted for donations and asset disposals)	1,729	1,679	3,998	3,995
Total Income	(37,209)	(37,407)	(112,608)	(112,943)
I&E Margin	**-4.65%**	**-4.49%**	**-3.55%**	**-3.54%**
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)		-4.49%		-3.54%
I&E Margin (Plan)		-4.65%		-3.55%
I&E Variance Margin	**0.00%**	**0.16%**	**0.00%**	**0.01%**
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	641	641	1,924	1,924
YTD Agency Expenditure	432	303	1,301	903
	-32.64%	**-52.75%**	**-32.38%**	**-53.07%**
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: M4
YEAR ENDING 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	(8,824)	(8,841)	17	(34,715)	(34,802)	87	(102,883)	(103,161)	278
Non-Clinical Income	(704)	(735)	31	(2,494)	(2,606)	111	(9,725)	(9,782)	57
Total Income	**(9,528)**	**(9,576)**	**48**	**(37,209)**	**(37,407)**	**198**	**(112,608)**	**(112,943)**	**334**
Expenditure									
Pay Costs	5,666	5,671	(5)	22,694	22,621	73	67,853	67,683	170
Non-Pay Costs	2,226	2,296	(70)	8,898	9,181	(283)	26,696	27,354	(659)
CNST	1,311	1,311	0	5,243	5,243	0	15,728	15,728	0
Total Expenditure	**9,202**	**9,277**	**(75)**	**36,835**	**37,045**	**(209)**	**110,277**	**110,765**	**(488)**
EBITDA	**(326)**	**(299)**	**(27)**	**(374)**	**(363)**	**(11)**	**(2,331)**	**(2,177)**	**(154)**
Technical Items									
Depreciation	366	359	7	1,466	1,454	12	4,419	4,423	(4)
Interest Payable	36	24	12	144	94	50	432	266	166
Interest Receivable	(1)	(0)	(0)	(3)	(5)	2	(10)	(15)	5
PDC Dividend	124	113	11	496	500	(4)	1,488	1,501	(13)
Profit / Loss on Disposal	0	0	0	0	0	0	0	0	0
Total Technical Items	**525**	**495**	**30**	**2,103**	**2,043**	**60**	**6,329**	**6,175**	**154**
(Surplus) / Deficit	**200**	**196**	**3**	**1,729**	**1,680**	**49**	**3,998**	**3,998**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M4
YEAR ENDING 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	340	360	(20)	1,362	1,402	(40)	4,085	4,152	(68)
Medical	1,248	1,251	(3)	4,990	4,954	36	15,078	14,938	140
Nursing & Midwifery	2,523	2,524	(2)	10,113	10,087	26	30,109	30,261	(151)
Healthcare Assistants	417	417	(1)	1,666	1,644	22	4,924	4,893	31
Other Clinical	546	526	21	2,185	2,130	55	6,554	6,487	68
Admin Support	140	165	(25)	562	629	(67)	1,679	1,870	(192)
Corporate Services	345	356	(11)	1,388	1,472	(84)	4,125	4,179	(54)
Agency & Locum	107	72	35	428	302	126	1,299	903	397
Total Pay Costs	**5,666**	**5,671**	**(5)**	**22,694**	**22,621**	**73**	**67,853**	**67,683**	**170**
Non Pay Costs									
Clinical Suppplies	709	710	(1)	2,836	2,843	(7)	8,521	8,535	(14)
Non-Clinical Supplies	572	601	(29)	2,215	2,466	(250)	6,768	7,259	(491)
CNST	1,311	1,311	0	5,243	5,243	0	15,728	15,728	0
Premises & IT Costs	414	457	(43)	1,668	1,756	(87)	4,978	5,184	(206)
Service Contracts	531	528	4	2,179	2,117	62	6,429	6,376	52
Total Non-Pay Costs	**3,537**	**3,606**	**(70)**	**14,141**	**14,424**	**(283)**	**42,424**	**43,083**	**(659)**
Total Expenditure	**9,202**	**9,277**	**(75)**	**36,835**	**37,045**	**(209)**	**110,277**	**110,765**	**(488)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M4
YEAR ENDING 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	(3,934)	(3,871)	(63)	(15,111)	(15,081)	(30)	(45,612)	(45,582)	(30)
Expenditure	1,708	1,642	66	6,839	6,806	33	20,501	20,655	(154)
Total Maternity	**(2,226)**	**(2,229)**	**3**	**(8,272)**	**(8,275)**	**3**	**(25,110)**	**(24,927)**	**(184)**
Gynaecology									
Income	(2,297)	(2,301)	4	(8,676)	(8,627)	(49)	(25,621)	(25,572)	(49)
Expenditure	859	861	(2)	3,436	3,456	(19)	10,309	10,393	(84)
Total Gynaecology	**(1,438)**	**(1,440)**	**2**	**(5,240)**	**(5,171)**	**(69)**	**(15,312)**	**(15,179)**	**(133)**
Theatres									
Income	(42)	(40)	(1)	(166)	(162)	(4)	(499)	(497)	(2)
Expenditure	640	561	78	2,560	2,554	5	7,679	7,644	35
Total Theatres	**598**	**521**	**77**	**2,393**	**2,392**	**1**	**7,180**	**7,148**	**33**
Neonatal									
Income	(1,358)	(1,357)	(1)	(5,423)	(5,645)	222	(16,249)	(16,668)	420
Expenditure	945	930	15	3,780	3,793	(13)	11,341	11,673	(332)
Total Neonatal	**(413)**	**(428)**	**14**	**(1,643)**	**(1,852)**	**209**	**(4,908)**	**(4,995)**	**88**
Hewitt Centre									
Income	(891)	(866)	(25)	(3,270)	(3,438)	168	(9,971)	(10,136)	165
Expenditure	623	593	30	2,490	2,531	(41)	7,471	7,634	(163)
Total Hewitt Centre	**(269)**	**(274)**	**5**	**(780)**	**(907)**	**127**	**(2,501)**	**(2,502)**	**2**
Genetics									
Income	(600)	(577)	(23)	(2,401)	(2,347)	(55)	(7,204)	(7,057)	(148)
Expenditure	478	409	70	1,913	1,640	273	5,739	5,201	538
Total Genetics	**(122)**	**(169)**	**46**	**(488)**	**(706)**	**218**	**(1,465)**	**(1,855)**	**390**
Clinical Support									
Income	(27)	(34)	7	(104)	(130)	26	(295)	(393)	98
Expenditure	752	786	(34)	3,083	3,122	(39)	9,098	9,353	(255)
Total Clinical Support & CNST	**725**	**752**	**(27)**	**2,979**	**2,992**	**(13)**	**8,803**	**8,960**	**(157)**
Corporate & Trust Technical Items									
Income	(378)	(529)	151	(2,057)	(1,978)	(78)	(7,158)	(7,038)	(119)
Expenditure	3,723	3,991	(268)	14,837	15,186	(349)	44,468	44,387	81
Total Corporate	**3,345**	**3,462**	**(117)**	**12,780**	**13,208**	**(428)**	**37,311**	**37,349**	**(38)**
(Surplus) / Deficit	**200**	**196**	**3**	**1,729**	**1,680**	**49**	**3,998**	**3,998**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M4
YEAR ENDING 31 MARCH 2018

BALANCE SHEET £'000	YEAR TO DATE Opening	M4 Actual	Movement
Non Current Assets	**72,688**	**73,170**	482
Current Assets			
Cash	4,897	10,568	5,671
Debtors	8,201	8,869	668
Inventories	366	352	(14)
Total Current Assets	**13,464**	**19,789**	**6,325**
Liabilities			
Creditors due < 1 year	(10,577)	(19,177)	(8,600)
Creditors due > 1 year	(1,717)	(1,706)	11
Loans	(17,175)	(17,175)	0
Provisions	(3,011)	(2,909)	102
Total Liabilities	**(32,480)**	**(40,967)**	(8,487)
TOTAL ASSETS EMPLOYED	**53,672**	**51,992**	**(1,680)**
Taxpayers Equity			
PDC	37,420	37,420	0
Revaluation Reserve	12,233	12,233	0
Retained Earnings	4,019	2,339	(1,680)
TOTAL TAXPAYERS EQUITY	**53,672**	**51,992**	**(1,680)**