Meeting of the Board of Directors
HELD IN PUBLIC
Friday 6 October 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)	
268	Apologies for absence & Declarations of interest	Receive apologies	Verbal	Chair		-
269	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		Well Led
270	Patient Story – Chaplaincy	To note an example of a patients experience at the hospital	Presentation	Patient	1340 (15mins)	Caring Responsive Well Led
271	Minutes of the previous meeting held on 1 September 2017	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1355 (5mins)	Well Led
272	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written/verbal	Chair		Well Led
273	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1400 (15mins)	Well Led
274	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						
275	Chair's Report from the Finance Performance and Business Development Committee	Receive assurance and any escalated risks	Written	Committee Chair	1415 (15mins)	Well Led
276	Chairs Report from the Putting People First Committee	Receive assurance and any escalated risks	Written	Committee Chair		Well Led
277	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						
278	Learning from Mortality Policy	To approve in light of the Board approved Mortality Strategies	Written	Medical Director/Associate Medical Director	1430 (10mins)	Caring Well Led
279	Freedom to Speak Up – National Guardian Survey 2017	The Board is asked to note the content of the report	Written	Director of Workforce and Marketing	1440 (10mins)	Caring Well Led
280	Safeguarding Annual Report 2016/17	The Board is asked to receive the report having been approved by GACA	Written	Mandy McDonough Associate Director of Safeguarding for Children and Adults Named Nurse & Midwife for Safeguarding Children	1450 (10mins)	Caring Well Led
281	Trust PLACE Assessment 2017	To Receive the PLACE Assessment following receipt by GACA	Written	Director of Nursing and Midwifery	1500 (10mins)	Safe Well Led
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES						
282	Safer Nurse/Midwife Staffing Monthly Report	The Board is asked to note the content of the report	Written	Director of Nursing and Midwifery	1520 (10mins)	Safe Well Led

Item no. 2017/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
283	Performance Report period 5, 2017/18	Review the latest Trust performance report and receive assurance	Written	Director of Operations	1530 (10mins)	Safe Well Led
284	Finance Report period 5, 2017/18	To note the current status of the Trusts financial position	Written	Director of Finance	1540 (10mins)	Well Led
TRUST STRATEGY						
285	Fit for Future Generations Update Northern England Clinical Senate Report - Review of Services Provided by Liverpool Women's NHS Foundation Trust	To brief the Board on progress and risks	Verbal	Chief Executive	1550 (10mins)	All
BOARD GOVERNANCE						
286	Board Assurance Framework	To review and approve any changes	Written	Director of Nursing and Midwifery/ Executive	1600 (10mins)	
287	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair		Well Led
HOUSEKEEPING						
288	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1610 End	Well Led

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

Meeting to end at 1610

1610-1625	Questions raised by members of the public observing the meeting on matters raised at the meeting.	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Board Agenda item 2017/271

Board of Directors

Minutes of the meeting of the Board of Directors
held public on Friday 1 September 2017 at 1400 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
Dr Andrew Loughney	Medical Director
Mr Jeff Johnston	Director of Operations
Mrs Michelle Turner	Director of Workforce & Marketing
Dr Doug Charlton	Director of Nursing & Midwifery
Mr Tony Okotie	Non-Executive Director/SID
Mr Ian Knight	Non-Executive Director
Mr David Astley	Non-Executive Director
Ms Jo Moore	Non-Executive Director

IN ATTENDANCE

Mr Colin Reid	Trust Secretary

APOLOGIES

Dr Susan Milner	Non-Executive Director
Mr Phil Huggon	Non-Executive Director

2017	
	Board Thank You Emma Howard, Head of Genetic Laboratories Ben Owens, Volunteer
234	**Apologies** – as above. **Declaration of Interests** – None
235	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
236	**Speak Up Guardian Annual report** The Director of Workforce and Marketing presented on behalf of the Speak Up Guardian, the Speak Up Guardian Annual Report. The Director of Workforce and Marketing advised on the creation of the mandated role in April 2016 explaining that the role came out of the recommendations from Sir Robert Francis' Freedom to Speak

Up review, published in February 2015.

The Director of Workforce and Marketing reported that Chris Mcghee had been appointed following an open and transparent process and that she undertakes the role alongside her role as Head of Nursing and Operations for Gynaecology and Anaesthetics.

The Director of Workforce and Marketing ran through the report highlighting the work of the Guardian and the ammeters she had addressed over the year. There was recognition from staff that this was a valuable role and that Chris was well thought of given her clam and considered approach and that those who had raised concern had always received feedback once the following the raising of the concern.

Jo Moore asked whether the Trust could benchmark to role with other organisation. The Director of Workforce and Marketing advised that this would be difficult to do given the differences in organisations and how they have implemented the role. The Director of Workforce and Marketing advised that the Trust had received very positive feedback from the National guardian on the implementation of the role and Chris's approach to the role.

The Medical Director asked whether there was any scope to have a second guardian in place to help cover the role. The Director of Workforce and Marketing advised that there was and this was being discussed with Chris and how this could be addressed, with possibilities of having an addition guardian employed by the Trust to sharing the role with other organisations.

The Board noted:

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. that consideration was being given to the future development of the role

237 Minutes of previous meeting held on Friday 7 July 2017

The minutes of the meeting held on 7 July 2017 were approved.

238 Matters arising and action log.

The Board noted that the action would be taken at a future meeting.

239 Chair's Announcements

The Chair made the following announcements:

Birmingham Women's and Children's NHS Foundation Trust: the Chair advised on the reciprocal visit that had been arranged for the Chair of Birmingham Women's and Children's NHS Foundation Trust to visit the Trust. He reminded the Board that he had previously visited the Birmingham Women's and Children's.

Council of Governors: The Chair reported that the election process for a number of governor constituencies was in full swing and would be concluded in October. He advised that announcement of the new governor appointments would take place at the Annual Members Meeting to be held on the morning of the 14 October 2017. The Chair advised that a number of discussion meetings with Governors had taken place on the strategic outline case. He reported that these had been welcomed by those governors attending.

Health and Wellbeing Event: The Chair congratulated the Health and Wellbeing team on the staff event that took place on 31 August 2017. He felt it was well organised and was well received by the staff over the day. The Chair asked the Director of Workforce and Marketing to pass on his thanks and

that of the Board to the team.

The Board noted the Chair's verbal update.

240 Chief Executive's report

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

The Chief Executive referred in particular to the Annual Members Meeting to be held on 14 October. She felt that the Trust would be able to articulate the clinical need for change as part of the requirement to explain future developments at the Trust.

Referring to the in-patient survey, the Chief Executive thanked all staff who go above and beyond in delivering the best possible quality and safe services to patients and it was a testament to this that the Trust had achieved the results.

The Board noted the Report from the Chief Executive.

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

Jo Moore, Chair of FPBD provided a verbal update on the meeting held on 29 August 2017. She explained that the Committee had received the Strategic Outline Case for the future of Liverpool Women's services and were assured by the content. The Committee also received the month 4 performance and financial reviews which would be discussed later in the meeting. Jo Moore advised that the Trust was on track to deliver the 2017/18 control total and had recognised the emerging risk in relation to the reduced activity in Gynaecology and the potential impact on 18 weeks referral to treatment time.

Referring to the Cost Improvement Programme, the Chair advised that there continued to be a shortfall against plan. This was being mitigated and there was confidence that the CIP would be delivered for 2017/18. She advised that 2018/19 would be a difficult year in delivery of CIP and it was imperative that plans were worked up and developed.

Jo Moore advised that there were no proposed changes to the BAF risks the Committee was responsible to review.

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

242 Chair's Report from the Audit Committee (AC)

Ian Knight, Chair of the AC provided an update on the work of the Committee held on 24 July 2017. He explained that it was the first meeting at which MIAA attended as the Trust's internal auditor and counter fraud provider. Ian Knight reported that RMS the previous internal auditor attended to provide their final report to the Committee and to pass the reins to MIAA.

Ian Knight advised that additional work was required to be undertaken on the procurement audit and this had been passed to MIAA to complete. He explained that there was some concern that audits had not been signed off appropriately by the Accountable Executive. It was therefore important that the Committee receives the sign off prior to the final report being received.

Ian Knight reported that the Committee had received a paper setting out the process for the appointment of the external auditor. He advised that the process would cumulate in a resolution to be passed by the Council of Governors at its meeting on 25 October 2017.

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

243 Chair's Report from the Governance and Clinical Assurance Committee (GACA)

The Chair asked for comments on the Chair's report from GACA.

Referring to the issues to be highlighted to the Board, the Medical Director updated the Board on the current status of the medicine management assurance and advised that since the initial concern was raised a number of meetings ago, it had been ascertained that CQC expectations on medicine management and standards had changed. He reported that the Deputy Director of Nursing and Midwifery was discussing with CQC what the new expectations where following which further discussions with Pharmacy would ensue, resulting in standards and indicators that could be measured. The Medical Director advised that as part of the management of this risk, the new Medicines Management Committee had been reconstituted and a chair of the committee identified.

The Board noted the content of the Chair's Report from the Governance and Clinical Assurance Committee.

244 Equality Delivery System Presentation

Cheryl Farmer, Equality and Human Rights Lead for the Trust joined the meeting to provide a presentation on "Equality Delivery System (EDS) and the Trust Board". She explained what EDS was and the expected goals arising from it, including: better health outcomes; improved patient access and experience; a fully representative and supported workforce; and inclusive leadership.

Referring to the goals that related to the Board; Inclusive Leadership , Cheryl Farmer explained that there were outcomes to inclusive leadership. The Board member was expected to: evidence how they meet the requirements; and self-assess – what grade they think they are achieving. An external assessment would be carried out to verify whether each Board member self-assessment.

Explaining the outcomes, Cheryl Farmer advised on the evidence that was needed that demonstrated their commitment to promoting equality both within and outside the Trust and in doing so recognise the equality impacts on matters presented in papers to the Board and main committees.

The Chair thanked Cheryl Farmer for her presentation and recognised the need to address gaps in showing that the Board, in all the things it did recognised the goal of inclusive leadership. He felt that there would be a need to hold a separate workshop to work through key gaps.

245 Feedback from Listening event – July 2017

The Director of Workforce and Marketing presented the feedback from the staff listening event that took place in July 2017 and explained that future events would be organised so that the Board could augment their visibility programme with the listening events.

The Director of Workforce and Marketing advised that the listening events and Board visibility programme were 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 were monitored through the Putting People First Committee. She explained the feedback from the first event that included:

- 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 Director of Workforce and Marketing referred the Board to the table of actions that the Trust would be measured against and sought the Boards consideration of the recommendations contained in the paper.

The Board:
- received the feedback from the first Listening Event;
- endorsed the approach and commitment to further regular Listening Events with staff; and
- agreed to provide challenge into the organisation and gain assurance that the feedback from staff was being acted upon.

246 Quarter 1 Mortality Report 2017/18

The Medical Director advised that the Board had previously been informed of the requirements of the National Quality Board and the Care Quality Commission that trusts were required to develop systems and processes to review and learn from the deaths of patients under their care. The expectation was that the Board of Directors oversee the work and receive quarterly reports on progress. Trusts were also required to adopt a policy that set down how they would meet the requirements. The Medical Director advised that the Board and GACA (on behalf of the Board) received at their May 2017 meeting the Trust's new Adult Mortality Strategy and Perinatal Mortality Strategy which were approved. He explained that the Policy was in production and would be approved through the governance structure.

Referring to the Report, the Medical Director advised that it was in it evolution stage and would develop over time and he had asked that future reports would be produced by Devender Roberts, Associate Medical Director who would present the findings to the Board. He advised that for Quarter one the Trust saw reductions in adult gynaecology deaths and non-termination stillbirths, with a small increase in neonatal deaths. The Medical Director felt that the Board could take assurance that for all specialties, the mortality rates remained within the expected range.

The Board discussed the content of the report and the possible themes and learning arising from it and noted that there detailed arrangements for the escalation and investigation of unexpected deaths across the Trust and the strategies agreed at Board and GACA were beginning to become embedded.

The Board noted the content of the report recognising that there had been adequate progress against the requirements laid out by the National Quality Board and confirmed that there was effective governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust. The Quarter 2 Mortality Report would be presented to the Board at the November 2017 Board meeting.

247 Safer Nurse/Midwife Staffing Monthly Report

The Director of Nursing and Midwifery presented the Safer Nurse/Midwife Staffing Monthly Report which was discussed. Referring to the "Reported Incidents of Reduced Staffing" table that showed the percentage of shifts where staffing fell below agreed levels and triggered a red rating, the Director of Nursing and Midwifery advised that although these were red-flagged the Trust was able to manage staffing within its relevant nursing and midwifery cohorts. The red-flags could be tracked for future reference to show any trends.

Ian Knight referred to the recruitment drive that took place in June and asked how often the Trust organised these. In response the Director of Nursing and Midwifery advised that they would be held usually once a year and would be dependent on whether there was a need to undertake the exercise.

The Director of Operations referred to the section on Care hours per patient day and asked whether the way the Report showed the indicator was correct. The Director of Nursing and Midwifery agreed to look at the indicator to address the concern and see how the indicator could be shown better.

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

248 (i) Health and Safety Annual Report 2016/17

The Director of Nursing and Midwifery presented the Health and Safety Annual Report 2016/17 and reported that the report had been reviewed by GACA prior to coming to the meeting.

The Director of Nursing and Midwifery referred the Board to the re-establishment of the Health and Safety Committee, whose work had previously been absorbed into the Safety Senate. He reported that as a consequence the Safety Senate had not been able to give as much time to the health and safety as the separate Health and safety Committee had and therefore the decision to re-establish the Health and safety Committee was made. David Astley agreed with this decision recognising the need to protect the culture of health and safety in the workplace.

The Board reviewed and received the Health and Safety Annual Report 2016/17. Ian Haythornthwaite asked that the dates are checked on page 5 as they did not tie into the date of the report.

(ii) Quality Strategy 2017-2020

The Medical Director advised that on 6 June 2017 the Board approved the Quality Strategy 2017-2020 following a recommendation received from its assurance committee Governance and Clinical assurance Committee (GACA). He reported that following approval he had received a number of comments from Senior Clinicians seeking revision to the Strategy 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'. The Medical Director advised that he had taken the revisions for review by GACA at its meeting on 17 July 2017 at which GACA approved the revisions. The Medical Director now sought approval of the amended Quality Strategy 2017-2020.

The Board agreed with the revisions proposed and approved the amended Quality Strategy 2017-2020.

249 Performance Report Period 4 2017/18

The Director of Operations presented the Performance Report for period 4 2017/18 and reported that the Trust was continuing to deliver all national targets to date. Referring to the table at the top of page 5, the Director of Operations reported that the figures did not include amongst other things, those poorly women that were receiving treatment at the Trust from consultants brought in from other providers and vice versa. The Medical Director referred to his paper that the Board members had seen and had also been presented to the Oversight Board which provided a brief account of the care provided to severely ill women by clinicians at the Hospital, either on-site or at other adult acute sites in the city and explained the problems encountered by clinicians in these circumstances.

The Board noted: the Performance Report for period 4 2017/18 report.

250 Financial Report & Dashboard Period 4 2017/18

The Director of Finance presented the Finance Report and financial dashboard for month 4, 2017/18 and reported that at Month 4 the Trust was slightly better than plan with an actual deficit of £0.196m against a plan of £0.200m and the Trust delivered a "Use of Resources" Rating of 3 in month which was equivalent to plan. CIP was slightly ahead of Plan overall, forecasting to deliver £3.7m for the year of which £0.7m was non-recurrent saving.

Ian Knight referring to the drop in Gynaecology activity asked whether this placed a pressure on delivery of the control total. In response the Director of Finance advised that there would be no impact given the block contract agreed with the CCG, however the CCG may look at the block contract for 2018/19 if activity was seen to reduce significantly.

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

251 Fit for Future Generations Update

The Chair opened the agenda item by referring to the publication of the Pre-Consultation Business Case (PCBC) in January 2017 which set out the preferred option and three additional options for the future of women's and neonatal services. He explained that for NHS England had asked for additional assurances before proceeding to public consultation; this included an independent clinical review and the affordability and sustainability of the options. In order to receive the assurance an independent body comprising of leading clinicians from the North of England had been commissioned with the financial and sustainable assurance, via a strategic outline case (SOC) being provided by the Trust. The financial and sustainable assurance looked at the capital requirements and affordability of the options and the resulting sustainability of Women's and Neonatal services. The Chair advised that both of the documents had been received by the Board and the SOC had been approved for submission to the regulator.

The Chair asked the Medical Director if he wished to add anything from the Northern England Clinical Senate Report. The Medical Director reported on the make-up of the Senate, which comprised of leading clinicians in their field of expertise: Paediatrics, Midwifery, Gynaecology, Oncologist's, Obstetrics Anaesthetics & Intensive Care and Neonatal and reported that none of the Senate members had any connections with the Trust or the North West so as to provide a totally independent view.

The Medical Director advised that the review undertaken by the Senate had been thorough and had looked at the process adopted by Liverpool CCG and the options it had addressed in the process. He advised that the Senate had concluded that the process had been very thorough and that no key stakeholder had been absent from the process. The Medical Director was pleased to report that the Senate had stated that it would be unsafe to split Obstetrics with Gynaecology. Referring to "being safe to stay on Crown Street", the Medical Director advised that the report was clear that there was real and significant risk of the services staying on the site and that their view was that when looking at the clinical risks the hospital should not remain on the site.

The Medical Director reported that the Senate in looking at all four options felt that the move to the University Campus site would be the best clinical option given the current configuration of health provider locations in Liverpool. Referring to the publication of the Report, the Medical Director advised that this decision rested with Liverpool CCG. The Chair thanked the Medical Director for the update and advised that the full report would be brought back to the Board following its publication by the CCG.

Referring to the second assurance document the 'Strategic Outline Case' (SOC), the Chair asked the Director of Finance if she wished to add anything to the discussion. The Director of Finance explained that as part of NHS England's assurance process they had requested a document that detailed the affordability and sustainability of the options contained in the PCBC. A significant amount of work had gone into the finalisation of the SOC, following which the Board had approved in so that it could be submitted to the regulators. The Director of Finance advised that once the SOC was submitted to the regulators a series of engagement meetings had been arranged to address any areas that required clarification.

The Chair thanked the Medical Director and Director of Finance for their comments and advised that it was the ambition of the Board that the CCG move to public consultation as soon as possible.

The Medical Director, in summing up his concerns if the preferred option was not accepted, advised that should this happen and the hospital remained on the crown street site there would be significant risks to the services that could be provided in the future. He felt this could lead to some services being closed and provided elsewhere with a significant loss of reputation to the Trust. The Medical Director felt there were big choices that needed to be made and stated that nothing stands still. The Medical Director referred to the fact that the women's hospital in Liverpool had moved locations when it had to, over the years it had been in existence.

David Astley felt that it was important as part of the public consultation that the Trust's clinicians were allowed to be heard. He felt that the new build should be seen as an investment in women health for the future.

The Chair in summing up the discussion recognised the clear clinical needs of the Trust in the provision of its services. He thanked the Board for their considerations and recognised that the next stage of the process would be the public consultation led by the CCG, who with the Trust would need to listen to the views of the public.

252 Review of risk impacts of items discussed

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

- Review of the role of the Speak Up Guardian
- Development of the EDS2 Goals
- Enhanced engagement and dialogue with staff
- Leaning from deaths
- Tracking of red-flags within the staffing report to look and any trends
- Transfers out - recognition this is a known risk.
- Risks associated with remaining on an isolated site – recognised in the BAF
- Reputational risk

253 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.

Date and time of next meeting

The Chair reported that the next meeting of the Board in public would be 6 October 2017

Agenda Item 2017/272

Liverpool Women's NHS Foundation Trust

TRUST BOARD
6 October 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	

Agenda Item	2017/274

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Chief Executive Report – October 2017**
DATE OF MEETING:	Friday, 06 October 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 – October 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

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.

Staff matters: Congratulations to Andy Sharp who was recently awarded best presentation at the International Congress of Hypertension in Pregnancy in Berlin where he presented LWH data on PLGF informed management of pre-eclampsia. Also to Angharad Care who was judged to have made the best oral presentation at national Preterm Conference in Leeds - she presented LWH RECAP study - randomised comparison between Arabin, progesterone and cerclage carried out in LWH and St Mary's Manchester (feasibility study). Congratulations to you both.

Governance arrangements: The Trusts Head of Governance recently left the Trust to pastures new and a recruitment process has been successful in finding a replacement. There will be a short delay in the replacement joining the Trust whilst he works his notice. Whilst he works his notice arrangements have been made to make sure the work of the Head of Governance is dealt with appropriately and interim measures have been adopted, including realigning the work to experienced members of the Governance team.

Board of Directors Listening Events: The board is holding quarterly listening events with a cross section of staff from all areas of the Trust. The next listening event is on the day of the Board meeting on 6th October 2017.

Knutsford IVF: The Hewitt Fertility Centre hosted an afternoon tea and open day on Sunday 17th September for families who have had successful IVF treatment in the centre's Knutsford based IVF clinic came along. People who

are considering fertility treatment were also invited earlier on in the day to speak with staff so they could find out more about the treatment options that are available. The event was very successful with over 100 families attending.

Midwives on the Move: I reported last month that our midwives were undertaking a 9 mile walk from the Pier Head to Otterspool and back on Saturday 16 September. They raised an amazing £1,600 to refurbish their HDU. Well done to everybody involved, especially Angela Winstanley who organised the event.

Director of Operations: Our very own Director of Operations will be running the Dublin Marathon on 29 October 2017 to raise money for the Liverpool Women's Charity. You can donate at: Justgiving.com/fundraising/jeff-johnston6

SECTION B – LOCAL

Liverpool Health Partners: Professor Sir Ian Gilmore, Chairman of Liverpool Health Partners will be finishing his term of office at the end of October. His replacement has yet to be identified.

Liverpool CCG: Liverpool CCG have announced on 14 September 2017 the appointment of Jan Ledward as Interim Chief Officer for NHS Liverpool CCG for a period of 9 months. Jan is a very experienced NHS senior manager who is currently Chief Officer for 2 CCGs in Lancashire.

Liverpool CCG: On Tuesday 26 September Liverpool CCG publication of the Northern England Clinical Senate Report into the Review of Services provided by the Trust. This is an independent report by eminent clinicians to ascertain, using the clinical evidence base and clinical standards described in the PCBC work to date, whether the clinical case for change, option appraisal development and proposals for consultation offer the best clinical options for sustainable, high quality and optimal patient experience for future Liverpool Women's services. The Report, which can be found in the Board papers, concluded in summary that the review panel:

- Agrees with the validity of the case for change and the service change proposals.
- Considers option D3-N (the new build on site adjacent to the Royal Liverpool Hospital) to be the most appropriate and sustainable of all four options.
- Considers the preferred option does support the strategic intent and policy direction of women's services nationally and women's and children's services locally.
- Does not consider the current 'workarounds' and inherent clinical risks to be sustainable.

Staff briefings took place on the findings. The Trusts medical director and CCG colleagues were involved in a range of media activities associated with the release of the report.

SECTION C - NATIONAL

National Institute for Health and Care Excellence Question Time and Public Board Meeting: NICE will be holding a Question Time session and Public Board Meeting at the Trust on Wednesday 21 November 2018. NICE hold their Question Time sessions and Public Board Meetings every other month in a different locations in the UK, usually in postgraduate centres or similar hospital location.

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 25 September 2017

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

2. **Agenda items covered**
   - ~ Strategic Outline Case Update: The Committee received a verbal update outlining the current status of the Trust's strategic outline case and feedback received from NHSI.
   - ~ Month 5 2017/18 Operational Performance Review: The Committee received Month 5 2017/18 performance dashboard. Work had progressed with the CQUIN targets since the last meeting, with most targets assessed as green. The Committee noted the impact of a shortage of junior doctors both at this Trust and within the region, after a recent closure at Whiston Hospital and Southport and Ormskirk Hospital difficulties to fill their junior doctor rotas.
   - ~ Month 5 2017/18 Finance Performance Review: The Committee received Month 5 2017/18 finance position and noted that at month 5 the Trust is continuing to forecast delivery of the full year control total. The monthly financial submission to NHSI is consistent with the contents of the report shared with the Committee. It was highlighted that a maternity provider has stopped making payments to the Trust for services. The matter has been escalated to NHSI. The Committee was informed of two budget virements reflected in month 5 position. Both relate to finalised CIP schemes: Four eyes scheme which equates to £550,000 and Genetics budget which equates to £204,000.
   - ~ Cost Improvement Programme (CIP) Update: The Committee received a CIP tracker report noting over-performance against plan of £116k in month 5 inclusive of mitigation actions. The Committee was cited to a potential financial risk due to a technology supplier not being able to deliver a solution to support the community redesign project as sold during the tendering exercise. Legal and expert procurement advice is being sought. 2018/19 CIP plans would be presented to the next FPBD meeting following consideration by the Trust Management Group.
   - ~ International Development Update: The Committee received a paper detailing the Trust's development of external business. The Committee asked for further clarification on the governance arrangements and requested further detailed information for its consideration.
   - ~ Fire Safety Update: The Committee received an update of progress against fire safety requirements. It was noted that a number of independent reports have been completed. It was agreed that the Committee should receive an overarching report at the October 2017 meeting.
   - ~ Emergency Planning, Resilience and Response Report (EPRR): The Committee received a report detailing Trust compliance against the EPRR core standards and was assured that the Trust has in place appropriate EPRR processes.
   - ~ Policies approved
     - o Managing Conflicts of Interest Policy: The Committee reviewed and ratified the policy which follows recent guidance from NHS England.
     - o Fraud and Bribery Policy: administration change to the named internal auditor within the policy approved. Not changes to content made.
   - ~ Sub Committee Chairs reports received
     - o Turnaround and Transformation Committee
     - o Digital Hospital Sub-Committee
       The Committee noted that the Trust had been successful in its bid to become a fast follower site. The Committee would be kept updated.

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
   - ~ As reported last month Gynaecology is not achieving contracted activity targets for a number of reasons that are being investigated. One of the reasons is the number of junior doctors available for clinics due to gaps in the rota, this is now having a significant impact on capacity. This is increasing the waiting time for follow up appointments and could impact upon the 18 week RTT (compliance now at 93.67 which is the lowest all year). The management team are reviewing the situation to find a solution to this issue.

5. Issues to highlight to Board
   - ~ Shortage of junior doctors - The Committee felt that the national shortage of junior doctors is becoming an increasing risk to the Trust. The Committee was made aware of the mitigation plans to upskill the nursing and midwifery workforce however this has the potential to impact on capacity to release staff time for training and impact on income and patient choice if the Trust doesn't have a capable workforce. This risk had also been addressed by the Putting People First Committee who had raised the risk to the BAF.
   - ~ International Development – The Committee felt that further detailed information regarding the governance arrangements was required.

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 Putting People First Committee meeting held 22 September 2017

1. Was the quorate met? Yes

2. Agenda items covered

~ Review of HR BAF Risks
~ Staff Experience Story – IM&T: The Committee welcomed a Lead Clinical Coder to provide an insight into the Coding team department and experience of working at this Trust.
~ IM&T response to Staff Survey results 2016: The Committee noted significant improvements to the senior management structure to support the IM&T team and the planned action to be taken to improve engagement. The environmental conditions of offices utilised by IM&T staff was escalated to the Committee's attention.
~ Directors of Workforce Report: The Committee noted updates on issues including the Listening Event to be held on 6 October 2017, Leadership Development Programme, NHS Staff survey, Disability Confident accreditation, and Pre-employment programme. The Committee supports the planned launch of the Flu Campaign on 9 October 2017. The Committee noted the appointment of a second Freedom to Speak Up Guardian as best practice, and the formal support of the dignity at work advisors up to the Freedom to Speak Up Guardians. The Committee also received a verbal report on the recent University of Liverpool Medical School Quality Assurance Visit. A written report will be provided upon completion however verbal feedback is predominantly positive.
~ Workforce Key Performance Indicator (KPI) Report (Month 5): The Committee noted that a Sickness Working Group had been established to review the sickness absence policy and audit compliance.
~ Medical Appraisal and Revalidation Annual Report 2016/17: The Committee received and approved the annual report 2016/17 and the statement of compliance. Both reports will be submitted to NHS England as part of quality assurance arrangements. The Committee supported the request to record medical appraisal data on one data system that reflects the 15 month cycle. The Committee recommended that Dr Topping presents to the Council of Governors to support public engagement with the revalidation process.
~ Contract Review: Payroll, Occupational Health and Equality and Diversity: The Committee noted that all outsourced services are performing well and delivering in terms of cost and quality. Further consideration of outsourcing recruitment and transactional services was noted.
~ Update on Seven Day Service: The Committee acknowledged the external pressures to meet the seven day service standards against the current workforce staffing pressures and current provision of on-site services. The Committee noted the self-assessment and action plan in place. They also noted the increased involvement of NHS England and NHS Improvement to meet the Seven Day Service priority standards.
~ Key Workforce Risks and Mitigating Actions: The Committee received a paper detailing the key workforce risks. It was reported that the most significant risk for the Trust is the ongoing shortages of junior doctors and succession planning around specialist nursing roles. Actions are in place to mitigate the decline in junior doctor staffing however the Committee is concerned about the longer term sustainability of medical rotas.
~ Workforce Race Equality Standard (WRES) Submission 2017: The Committee received assurance that the Trust is complying with the specific duties of the Equality Act 2010.
~ Guardian of Safe Working Hours – Quarter 1 2017/18: The Committee noted the work undertaken by the Guardian of Safe Working Hours to ensure that doctors are safely rostered. It was escalated to the Committee's attention the increasing number of shift gaps and number of locums and consultants used to backfill due to the shortage of junior doctors. The Committee reviewed the corporate risk 1743 in relation to a competent and capable workforce and considered the current score.

NHS

- ~ Staff Engagement Report including update on PULSE and Friends and Family Test: The Committee was assured by the staff engagement activities underway and is meeting the objective of the PPF strategy.
- ~ Policies approved
  - o Expenses Policy
  - o Study Leave Policy
  - o Performance Development Review Policy
  - o Policy for Managing Conflicts of Interest
  - o Whistleblowing Policy and Fraud and Bribery policy
- ~ Sub Committee Chair Reports
  - o Health and Wellbeing Group held 26 June and 8 August 2017
  - o Nursing and Midwifery Board held 27 June and 25 July 2017
  - o Partnership Forum held 5 September 2017
  - o Diversity and Inclusion held 13 September 2017
  - o Education Governance Committee held 12 September 2017

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 PPF Performance Measures

The Committee noted that the sickness analysis over a 5 year period demonstrated a 60% long term and 40% short term sickness split as a constant pattern year on year. Anecdotal evidence had been received from the Trust's Occupational Health providers advising that this Trust submits more management and self-referrals for mental health issues compared to other local Trusts. There is also evidence that the sickness absence policy is not used consistently across the Trust. A sickness working group has been established to review the sickness and absence policy and audit compliance.

5. Issues to highlight to Board of Directors

- ~ IM&T Estate – The Committee noted the concerns of the Deputy Chief Information Officer in relation to the working conditions of the office space utilised by the IM&T teams, in particular the portakabin. The Committee advised the Board that they should support the action to convene a Space Utilisation Committee to consider alternative accommodation.

- ~ Seven Day Service – The Committee noted the difficulties to achieve the priority standards on site due to the provision of on-site services available and reflects the clinical need for change.

- ~ Shortage of junior doctors - The Committee felt that the national shortage of junior doctors is becoming an increasing risk to the Trust. This is further impacted with an increasing gap of specialist nursing roles. The Committee reviewed the corporate risk in relation to a competent and capable workforce and recommends that the Board approves an increase of the risk score to 20.

  Risk 1743: Likelihood 4 x Impact 5 = risk score of 20

6. Action required by Board of Directors

1) Approve escalation of corporate risk 1743 to the Board Assurance Framework.

AUTHOR NAME: David Astley

DATE: SEPTEMBER 2017

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Governance and Clinical Assurance Committee meeting held 18 September 2017

1. Was the quorate met? Yes

2. Agenda items covered

~ Safeguarding Annual Report 2016/17 and Safeguarding Training Strategy: The Committee received the 2016/17 Safeguarding Annual Report and Safeguarding Training Strategy. The Committee noted that the objectives for 2016/17 had been achieved set out in the Annual Report. The Safeguarding Annual Report will be presented to the Board at the October meeting. Safeguarding Training Strategy - The Committee was assured that a comprehensive, robust and up to date safeguarding training programme is in place and has achieved full compliance for the Trust. The strategy now includes child sexual exploitation training packages and staff training needs analysis which was not provided previously.

~ Thematic Review of Incidents: The Committee received the report and noted that there has been a one third increase in reported incidents. When LWH is benchmarked against other Trusts, it is now in the top quarter, which shows a significant increase over the last 3 years. This was seen as a positive position that there was a culture of reporting however minor.

~ Serious Incidents Report: The Committee was advised that there had been no Serious Incidents declared since the report in July 2017. The Committee was assured that there was evidence of serious incident reporting and investigations making a difference to learning although there was a growing concern that a number of action plans were now overdue, mainly in Gynaecology. This had been highlighted in the GACA performance Report. A discussion was required in the Safety Committee to understand the reason for the delays in closing action plans as the responsible Committee. GACA would review this again at its meeting in November when the Committee was assured there would be improvements.

~ Annual Update on the Francis Report: The Committee received the annual update on the action plan arising from the Francis Report recommendations. There was one outstanding part to the action for recommendation 244. This would only be delivered once the EPR was in place. There was discussion on whether the whole of the action should remain Red given the remaining 4 parts of the recommendation had been closed. It was agreed to record the decision to leave the action Red.

~ Quality and Regulatory Improvement Requirements: The Committee received this report which highlighted some concerns following an MIAA in house inspection of gynaecology and in-patient maternity services that raised a number of concerns such as own goal in terms of case note being left unattended. The Committee was assured that these concerns were being addressed and requested that the committee receives an update at its next meeting.

~ Safety, Effectiveness & Experience (SEE) Report Quarter 1 2017/18: The Committee received the SEE report and noted that there was no requirement to escalate any concerns to the Board.

NHS

- ~ **GACA Performance Indicators Report M4:** The Committee received Month 4 2017/18 performance dashboard. Also see SI Report and Quality and Regulatory Improvement sections above. The Committee was not assured that the Senates were appraising the indicators appropriately and have requested that this is addressed.
- ~ **Research and Development Strategy:** The Committee received a verbal update on the development of the Strategy from the Medical Director who advised that the Strategy was not ready to come to GACA and Board until November/December respectively.
- ~ **Patient Led Assessment of the Care Environment (PLACE) Assessment 2017:** The Committee received assurance on the PLACE Assessment and was pleased that the results were mainly good results and positive comments but with some reduction in results compared to 2016 largely due to the refurbishment works at the time of the assessment. Since the assessment the works have been completed and provide an enhanced environment for patients, staff and visitors which should be reflected in 2018 results.

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

Please see SI Reporting and Quality and Regulatory Improvement Reports. There is some concern that the Senates were not appraising the indicators they are responsible for prior to coming to GACA.

5. Issues to highlight to Board

- ~ The Committee would like to advise that a GACA review workshop has been held and the final report had a number of recommendations that were being considered by the Committee Chair, Director of Nursing and Midwifery and the Trust Secretary.

6. Action required by Board

- ~ Receive the Safeguarding Annual Report 2016/17
- ~ Receive the Patient Led Assessment of the Care Environment (PLACE) Assessment 2017 report 2017

Susan Milner
Chair of GACA

Agenda Item	17/278

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Learning from Deaths Policy**
DATE OF MEETING:	Friday, 06 October 2017
ACTION REQUIRED	**For Approval**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	34T
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: **34T**	☒ ☒
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 Learning from Deaths Policy***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Or type here if not on list: 34T	
	Date of meeting		34T	

Executive Summary

In May/July the Board /GACA received and approved the Adult Mortality Strategy and the Perinatal Mortality Strategy that had been produced in response to national guidance. The Board had 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.

At the September 2017 Board meeting the Board received the first quarterly mortality report. This report detailed 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 concluded that there was currently evidence available that adequate progress was 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.

The attached Policy goes further to meet the requirements of National Quality Board that all trust have in place a Learning from Deaths Policy.

The Board is asked to approve the policy.

Learning from Deaths Policy

Liverpool Women's NHS Foundation Trust

Version 1.0
October 2017

Designation of Policy Author(s)	Medical Director
Policy Development Contributor(s)	Medical Director Head of Governance
Accountable Director(s)	Medical Director
Ratified By (Committee / Group)	Board of Directors Policy Committee
Date ratified	(Draft – not yet approved)
Date issued/published on Intranet	(To be updated once published)
Review date	(To be updated once published)
Target audience	Trust Wide

The Trust is committed to a duty of candour by ensuring that all interactions with patients, relatives, carers, the general public, commissioners, governors, staff and regulators are honest, open, transparent and appropriate and conducted in a timely manner. These interactions be they verbal, written or electronic will be conducted in line with the NPSA, 'Being Open' alert, (NPSA/2009/PSA003 available at www.nrls.npsa.nhs.uk/beingopen and other relevant regulatory standards and prevailing legislation and NHS constitution)

It is essential in communications with patients that when mistakes are made and/or patients have a poor experience that this is explained in a plain language manner making a clear apology for any harm or distress caused.

The Trust will monitor compliance with the principles of both the duty of candour and being open NPSA alert through analysis of claims, complaints and serious untoward incidents recorded within the Ulysses Risk Management System.

Contents

1 Introduction

Approximately 500 000 people die in the UK every year and of these, nearly half die in an NHS hospital.[1] The CQC and NHS England have recently highlighted the need for NHS Trusts to learn from their experiences when someone in their care has died so that services can be optimised and clinical practice improved.[2,3] Most of the adult deaths that are encountered at Liverpool Women's NHS Foundation Trust are the expected end point of a known disease process and significant deficiencies in care leading directly to perinatal deaths are rare in the organisation. Nevertheless, the need to learn is embraced by the Trust as an essential response to each and every death it encounters.

The Trust's Adult Mortality Strategy and its Extended Perinatal Mortality Strategy describe the causes of mortality and the methods by which the risk of death can be minimised. The strategies also describe the ways in which learning should take place, through the processes of 'analysis' and 'response'. These learning processes are formalised into Trust Policy in the present document.

This policy is relevant and applies to all of the Trust's clinical and managerial staff because the management of adult mortality and extended perinatal mortality is a shared responsibility.

2 Aims of the Policy

2.1 Analysis

The Trust gathers detailed intelligence on all individual instances of adult mortality and extended perinatal mortality that it encounters in its patient population, identifying local issues and themes arising from those events.

2.2 Response

The Trust responds to its analyses by the production of SMART Action Plans, seeing those plans through to completion and disseminating the intelligence gathered to all relevant clinical and

managerial groups. After completion of these action plans the Trust ensures that full benefit has been achieved by measuring relevant and related clinical outcomes.

3 Analysis and Response in Adult Mortality

The Trust's policy for analysis after an adult death relies upon the following activities:

- gathering detailed intelligence on all individual instances of adult mortality in the Trust
- identifying local issues arising from each of those events individually
- exploring themes that may be emerging from groups of events.

3.1 Intelligence-Gathering Process

Appendices A, B and C are flow charts that illustrate the intelligence-gathering processes that are followed after expected gynaecological deaths, unexpected gynaecological deaths and all adult deaths in obstetrics. Expected gynaecological deaths are those that arise as the predicted end point of a known disease process. In this Trust, most of these result from gynaecological cancers.

3.2 Adult Mortality Audit Sheet

Whenever there is an adult death in the trust, whether expected or not, an Adult Mortality Audit Sheet is completed (the content of which is included as Appendix D). This records performance against a predefined set of standards, using the recognised and validated methodology detailed in PRISM studies.[4] In each clinical area, the Clinical Director provides feedback to clinicians if individual errors or omissions in care have been identified by use of this audit tool. The forms gathered are passed to the Head of Governance, who pools the data and identifies any emerging Trust-wide themes. These are highlighted in the Quarterly Adult Mortality Report.

3.3 Root Cause Analysis

For unexpected gynaecological deaths and all maternal deaths, either a Level 2 or a Level 3 Root Cause Analysis is performed. One of the main aims of the Root Cause Analysis is to identify case-specific errors and systematic flaws. All Root Cause Analyses are scrutinised by the Head

of Governance, who pools data and identifies any emerging Trust-wide themes. The lessons learnt and the SMART Action Plans are highlighted in the Quarterly Adult Mortality Report.

3.4 SMART Action Plans

After the analysis of events following an adult death areas of deficiency and opportunities for improvement are presently captured by the production of SMART Action Plans. Similarly, after completion of any clinical audit of relevance to adult death, areas of deficiency and opportunities for improvement are captured by the production of SMART Action Plans:

- specific
- measurable
- agreed
- realistic
- time-based.

Each action in a SMART Action Plan has an assigned person responsible for its completion. This may for example be the Safety Lead, the Effectiveness Lead, a senior nurse or midwife or a manager. Progress against Action Plans is discussed as a routine agenda item at Directorate Clinical Meetings.

The Head of Governance provides oversight and prompts the assigned person responsible if an action is overdue for completion. If a planned action relating to adult mortality has not been completed within one month of its agreed completion date, The Head of Governance escalates the matter to the Medical Director and the Director of Nursing and Midwifery, who pursue completion of the action.

When any action in a SMART Action Plan is being closed relating to adult mortality, evidence must be attached to show how the requirements of that action have been met. In addition, beyond completion of a SMART Action Plan, the Trust ensures that full benefit has been achieved by measuring relevant and related clinical outcomes. These outcome measures are agreed at the Directorate Clinical Meetings and monitored at those same meetings with the assistance of the Head of Governance.

3.5 Quarterly Adult Mortality Report

The Head of Governance produces a Quarterly Adult Mortality Report. As a minimum, this report contains data about:

- number of adult deaths
- number of women who had an Adult Mortality Audit Sheet completed
- number of woman whose death lead to a Root Cause Analysis
- number of deaths attributable to deficiencies in care
- themes identified from the Adult Mortality Audit Sheets and Root Cause Analyses
- actions being taken
- progress against those actions
- outcome measures identified for on-going scrutiny, beyond completion of action plans.

In a broader sense, the Quarterly Adult Mortality Report contains information relevant to all of the activities outlined in the Adult Mortality Strategy, including activities around prevention, analysis, response and bereavement. The Head of Governance presents the Quarterly Adult Mortality Report to GACA and The Medical Director presents the Quarterly Adult Mortality Report to the public meeting of the Board of Directors, to give assurance. A summary of the year's Quarterly Adult Mortality Reports is used by the Head of Governance to populate the Quality Accounts of the Trust.

4 Analysis and Response in Extended Perinatal Mortality

4.1 Neonatal Death

MBRRACE suggest that after all neonatal deaths, the Trust providing the clinical care should conduct a full review of the care provided, identify any local factors that might be responsible for high mortality rates and establish whether there are lessons to be learned to improve the quality of care. At Liverpool Women's Hospital, an initial assessment is made immediately after all neonatal deaths (including early neonatal deaths) by neonatal medical and nursing leads, at which time the following questions are asked:

- Does the death meet the threshold for triggering a SUDI investigation? (Sudden Unexplained Death in Infancy)
- Does the death require discussion with the Coroner?
- Does the death require reporting as a Serious Incident?

If the death is a SUDI a police investigation takes place and this has precedence over all other investigatory work. Staff are required to make a written record of their involvement as soon as possible after the event and is converted into a police statement if required.

If the death is not a SUDI but the Coroner decides that a Coroner's Investigation is required, a post mortem examination will normally be carried out on the Coroner's direction. The Trust is provided with the post mortem result only after being given permission by the Coroner. The Trust accepts that this can delay parallel in-house investigations that may be taking place.

If a Serious Incident (SI) investigation is required, this can progress at a normal pace unless there is a SUDI, which takes precedence. If there is a Coroner's Investigation taking place in parallel with an in-house Serious Incident investigation, the Trust's investigators will normally reach a preliminary provisional conclusion while waiting conclusion of the Coroner's Investigation and complete their report thereafter. Each SI report includes a Lessons Leaned section and a SMART Action Plan, completion of which is monitored by the Neonatal Clinical Meeting. Importantly, SI reports are shared with the woman who has suffered a neonatal death and an opportunity is given for them to discuss the findings will a Consultant Neonatologist.

In addition to the above, a multi-disciplinary panel of doctors and nurses on the Neonatal Unit use a locally created standardised audit tool to review all neonatal deaths. The aim of these reviews is to agree the cause of death, to determine whether there were any deficiencies in care delivery and to decide whether these deficiencies were likely to have had any causal role in the death. A CESDI code is also determined at this meeting. Learning points arising from these panel reviews are communicated to the wider team by email, at daily handover meetings and at the Neonatal Clinical Meetings.

Selected individual cases are presented to a Trust Bi-Annual Perinatal Mortality Meeting. Cases are selected for presentation that will be of interest to both the neonatal and maternity clinicians who are in attendance at those meetings.

A summary of the data collected from the Trust's neonatal death reviews is reported to the Cheshire and Mersey neonatal network Clinical Effectiveness Group (CEG), along with any learning points generated. All deaths are also reported to the local Child Death Overview Panel (CDOP) and are discussed there. One of the neonatal Consultants from the Trust attends the CDOP to inform this discussion and to feed back any relevant points from the discussion to the Neonatal Clinical Meeting.

An annual summary report of all neonatal deaths, including SUDI, coroner's cases, SIs and others, is compiled to demonstrate themes and these are used to drive targeted service change. The annual report is reviewed at the Neonatal MDT meeting and it is also presented to the Effectiveness Senate. The data generated after SUDIs, Coroner's Investigations and SIs are also included in the Trust's Annual Extended Perinatal Mortality Report – including Lessons Learned, SMART Action Plans generated and themes arising from early neonatal deaths.

With respect to benchmarking, the Trust is involved in several initiatives in addition to the MBRRACE-UK report:

The Vermont Oxford Neonatal network collects data that allow us to benchmark our very low birthweight and extreme preterm in-hospital mortality against other neonatal units across UK and across the world, with risk adjustment for case mix.

The Quality Account publishes data about neonatal mortality for babies born at the Trust, compared with the national neonatal mortality rates published by the Office for National Statistics, with adjustment for the gestation profile.

The Neonatal Data Analysis Unit also produces an annual report on in-hospital mortality for preterm babies in UK neonatal units.

The Healthcare Quality Improvement Partnership is presently working with the RCOG and the British Association of Perinatal Medicine to developing a standardised Perinatal Mortality Review Tool (PMRT), for use when investigating perinatal deaths. The PMRT is due to be released by the end of December 2017 and after that time the Trust is committed to adopting it for local use. Data generated from use of the PMRT will be included in future editions of the Annual Extended Perinatal Mortality Report together with benchmarking data.

4.2 Stillbirth

The Trust has a well-embedded process for stillbirth review. The key steps are as follows:

A central register of all stillbirths is kept locally by the Head of Midwifery. The Clinical Coding department sends the Head of Midwifery a monthly update showing all coded stillbirths so that the local list and the external coding data correlate correctly, ensuring that there are no cases being missed from the investigatory process.

All non-fetal abnormality stillbirths are recorded as adverse events using the Trust incident reporting system, Ulysses.

The Clinical Director, Clinical Governance Lead and Head of Midwifery review all stillbirths and agree whether an SI investigation, formal review or multidisciplinary team review is required. Stillbirths identified as requiring SI investigations generate a formal report identifying Lessons Leaned and a SMART Action Plan, completion of which is monitored by the Maternity Clinical Meeting. A copy of each report is sent to all staff involved in the delivery of care so that they can be discussed with Educational Supervisors and Supervisors of Midwifery as appropriate. The Lessons Learned are shared more widely via email and at the Maternity Clinical Meetings, in keeping with the Trust's Policy for Managing Incidents and Serious Incidents. A copy of the report is also sent to CCG and the CQC, who may choose to add scrutiny to the event. Importantly, SI reports are shared with the woman who has suffered a stillbirth and an opportunity is given for them to discuss the findings will a Consultant Obstetrician.

All Intrapartum stillbirths are declared SIs and in addition to SI reports, intrapartum stillbirths also undergo review using the Each Baby Counts review process. For these reviews, the Strategic

Clinical Network provides an external panel member. The report generated is uploaded on to the Trust shared drive and is shared nationally.

All stillbirths are presently audited using an in-house audit tool and the data generated are presented to the Trust Bi-Annual Perinatal Mortality Meeting. Standards of care in each case are graded according to CESDI criteria.

The Trust has previously published the results of its continuous stillbirth audit as an annual stand-alone report. From December 2017, data generated from this continuous audit and the Lessons Learned and SMART Action Plans generated after SIs will be included in the Trust's Annual Extended Perinatal Mortality Report.

With respect to benchmarking, the Trust receives yearly figures on its performance through MBRRACE-UK, in which an attempt is made to match local outcomes with national peers. The Trust's Associate Medical Director for Clinical Governance produces a response to the annual MBRRACE-UK report at the time of its publication. This response takes into account local factors that have not otherwise been accounted for in the MBRRACE-UK document. This response is included in the Trust's Annual Extended Perinatal Mortality Report.

4.3 Annual Extended Perinatal Mortality Report

The Trust has been auditing stillbirth since 2004 and in recent years, this has taken the form of a continuous audit published as the Annual Stillbirth Audit. This included information about stillbirth rates, cause specific conditions and benchmarking data, measuring practice against our expected standards of care. Themes such as obesity, ethnicity, deprivation, reduced fetal movements and growth have been explored in the reports as mini-summaries.

Early neonatal mortality rates have been reported and commented on annually since the Trust was founded, initially in the Neonatal Unit annual report and latterly in the Trust Quality Account. All neonatal deaths within the Trust in recent years have been subject to multidisciplinary team review using a standard methodology in order to identify areas for service improvement and ad-

hoc reports if the data produced by this approach have been produced to inform service development priorities.

The stillbirth and early neonatal death audit work are now incorporated into an Annual Extended Perinatal Mortality Report, additional elements of which are described in the Extended Perinatal Mortality Strategy. Production of the Annual Extended Perinatal Mortality Report is the responsibility of the Associate Medical Director for Clinical Governance in conjunction with the Clinical Directors, Safety and Effectiveness Leads from Maternity and Neonatology and the Trust's Head of Governance. The report is presented to meetings of GACA, which is a sub-committee of the Board of Directors, on an annual basis.

5 Learning Disabilities

The Trust recognises that at the present time, there is no agreed approach to the performance of case review after the death of an adult with learning disabilities. The Trust is committed to the production of a Standard Operating Procedure for this circumstance by the end of 2017. The work will be lead by the Medical Director and the Head of Adult Safeguarding. It will include a commitment to the use of LeDeR methodology, which is a University of Bristol initiative commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England.[5] The Standard Operating Procedure will be introduced after discussion and agreement of its content at the Effectiveness Senate.

6 Duties and Responsibilities of Individuals

6.1 All Staff

It is the responsibility of all staff to minimise the risk of adult and extended perinatal mortality and to minimise its impact. To highlight areas for improvement, the Trust's risk management processes may be used. Issues may also be brought directly to the attention of Safety or Effectiveness Leads, Clinical Directors, senior nursing and midwifery staff, Divisional Managers, the Associate Medical Director for Clinical Governance, the Medical Director or the Director of Nursing and Midwifery for consideration, escalation and action.

6.2 Medical Director

The Medical Director sponsors the Adult Mortality Strategy and has lead responsibility for its delivery. The Medical Director presents the Quarterly Adult Mortality Report to the public meeting of the Board of Directors for assurance. With respect to extended perinatal mortality, the Medical Director works with the Associate Medical Director for Clinical Governance to agree the content of the Extended Perinatal Mortality Strategy and oversees its delivery. More generally, the Medical Director has joint responsibility for clinical governance in the Trust and with respect to adult and extended perinatal mortality, provides the function of 'Patient Safety Director.'

6.3 Non Executive Director

The Non Executive Director who Chairs the meetings of GACA, in conjunction with the Medical Director, takes oversight of the process for reviewing and reporting on adult and extended perinatal death in the Trust.

6.4 Director of Nursing and Midwifery

The Director of Nursing and Midwifery has joint responsibility for clinical governance, delegated authority for quality improvement and risk management and is the Executive Lead for infection control. The Director of Nursing and Midwifery supports delivery of the Adult Mortality Strategy and the Extended Perinatal Mortality Strategy.

6.5 Associate Medical Director for Clinical Governance

The Associate Medical Director for Clinical Governance assists the Medical Director and the Director of Nursing and Midwifery in delivering the commitments made in the Adult Mortality Strategy. The Associate medical Director for Clinical Governance also sponsors the Perinatal Mortality Strategy and has lead responsibility for its delivery. The Associate Medical Director for Clinical Governance presents the Annual Extended Perinatal Mortality Report to GACA and ensures that it is also discussed and debated at the Maternity and Neonatology Clinical Meetings.

6.6 Head of Governance

The Head of Governance works with Medical Director, the Director of Nursing and Midwifery and the Associate Medical Director for Clinical Governance, to support delivery of the Adult Mortality Strategy. The Head of Governance produces the Quarterly Adult Mortality Report, presents it to GACA and includes a summary of it in the Trust's Annual Quality Accounts. The Head of Governance also works with Associate Medical Director for Clinical Governance, the Medical Director and the Director of Nursing and Midwifery, to support delivery of the Extended Perinatal Mortality Strategy. The Head of Governance assists the Associate Medical Director for Clinical Governance in producing the Annual Extended Perinatal Mortality Report and includes a summary of it in the Trust's Annual Quality Accounts.

6.7 Safety Leads

Safety Leads are usually consultants in the trust, but at the joint request of the Medical Director and the Director of Nursing and Midwifery, senior nursing or midwifery staff can also hold these posts. Safety Leads take responsibility in their own clinical areas for a range of clinical governance activities of relevance to the Adult Mortality Strategy and the Extended Perinatal Mortality Strategy, including the promotion of incident reporting, identifying cases requiring Serious Untoward Incident investigations, ensuring completion of action plans after Serious Incident investigations, disseminating clinical lessons learnt and co-ordinating responses to national reports or initiatives. In conjunction with their Clinical Directors and the Effectiveness Leads, they assist the Associate Medical Director for Clinical Governance in producing the Annual Extended Perinatal Mortality Report.

6.8 Effectiveness Leads

Effectiveness Leads are usually consultants in the trust, but at the joint request of the Medical Director and the Director of Nursing and Midwifery, senior nursing or midwifery staff can also hold the posts. Effectiveness Leads take responsibility in their own clinical areas for a range of clinical governance activities of relevance to the Adult Mortality Strategy and the Extended Perinatal Mortality Strategy, including the maintenance of clinical guidelines, formulation and delivery of clinical audit, benchmarking and horizon scanning. In conjunction with their Clinical Directors and

the Safety Leads, they assist the Associate Medical Director for Clinical Governance in producing the Annual Extended Perinatal Mortality Report.

6.9 Senior Managers

Senior managers take a leading role in the management of clinical risks in the Trust, including the management of risks relating to adult and extended perinatal mortality. Examples of their responsibilities include escalating clinical risks from the front line, identifying the actions needed to reduce the risk, assigning owners to elements of Action Plans and monitoring mitigating factors.

7 Committees and Meetings

7.1 Directorate Clinical Meetings

Directorate Clinical Meetings are open to attendance by all medical, nursing and midwifery staff of the relevant directorate. Standing items on their agenda of relevance to the Adult Mortality Strategy include review of the Directorate Risk Register, review of progress against the Clinical Audit Forward Plan, review of the actions detailed in SMART Action Plans after an adult death, review of the actions detailed in SMART Action Plans after a relevant clinical audit, horizon scanning and review of the Quarterly Adult Mortality Report. Standing items of relevance to the Extended Perinatal Mortality Strategy include review of the Directorate Risk Register, review of progress against the Clinical Audit Forward Plan, review of the actions detailed in SMART Action Plans, horizon scanning and review of the Annual Extended Perinatal Mortality Report.

7.2 Safety Senate

The Safety Senate monitors themes arising from clinical incidents that have been reported in the Trust, including those that have arisen following an adult or an extended perinatal death. In addition, after a Serious Incident, although the Directorate Clinical Meetings monitor progress against the SMART Action Plans produced, the Safety Senate provides monthly oversight and escalates unresolved risks to GACA.

7.3 Effectiveness Senate

The Effectiveness Senate monitors progress against the Trust's Clinical Audit Forward Plan, which includes audit work in those clinical activities most closely related to the risk of adult mortality and extended perinatal mortality. In addition, although the Directorate Clinical Meetings monitor progress against the SMART Action Plans produced after their clinical audits, the Effectiveness Senate provides monthly oversight and escalates unresolved risks to GACA.

7.4 Governance and Clinical Assurance Committee

The Governance and Clinical Assurance Committee (GACA) is the sub-committee responsible for providing the Board of Directors with assurance on all aspects of quality of clinical care. GACA therefore oversees all clinical governance activity relating to mortality. It meets on alternate months and receives, via the Effectiveness Senate and Safety Senate Chairs' Reports, risks relating to mortality mortality that have not been resolved at directorate or senate level. In addition, it receives the Quarterly Adult Mortality Report and escalates unresolved risks relating to adult mortality to the Board of Directors. Since the Quarterly Adult Mortality Report is also provided directly to the Board of Directors, which meets monthly, it is accepted that the Board of Directors will occasionally receive an Adult Mortality Quarterly Report before it has been considered by GACA. In addition, GACA receives the Annual Extended Perinatal Mortality Report and escalates unresolved risks relating to extended perinatal mortality to the Board of Directors.

7.5 Board of Directors

The Board of Directors meets in public on a monthly basis. It has the overarching responsibility for activities relating to mortality in the Trust. It therefore receives the Quarterly Adult Mortality Report for direct consideration. It also receives assurance from GACA with respect to the detailed elements of the report, via the Chair of GACA's Report. The Board of Directors also receives assurance from GACA with respect to the detailed elements of the Annual Extended Perinatal Mortality Report, via the Chair of GACA's Report. In addition, the following items of relevance to adult mortality and extended perinatal mortality appear on the Board Assurance Framework: (i) the isolated site of Liverpool Women's Hospital, (ii) transport of adults across the critical care network, (iii) development and support of a comprehensive Clinical Audit Forward Plan, (iv)

ensuring that lessons are learnt and change enacted from the reporting and investigation of incidents locally and across the NHS and (v) considering response to NICE Guidance**.**

8 Monitoring Compliance

Compliance with the commitments made against adult mortality in this policy document will be monitored via the Quarterly Adult Mortality at GACA and at the Public meeting of the Board of Directors. Compliance with the commitments made against extended perinatal mortality in this policy document will be monitored via the Annual Extended Perinatal Mortality Report at GACA. This strategy will be reviewed and updated annually by the Medical Director and the Associate Medical Director for Clinical Governance.

9 Dissemination and Access to the Document

This policy will available on the Trust intranet from November 2017. All staff will be notified that the policy is available on the intranet and will be notified by email is any amendments are made at a later date.

10 Evidence Base

1. Office for National Statistics, Death registrations summary tables – England & Wales for 2015

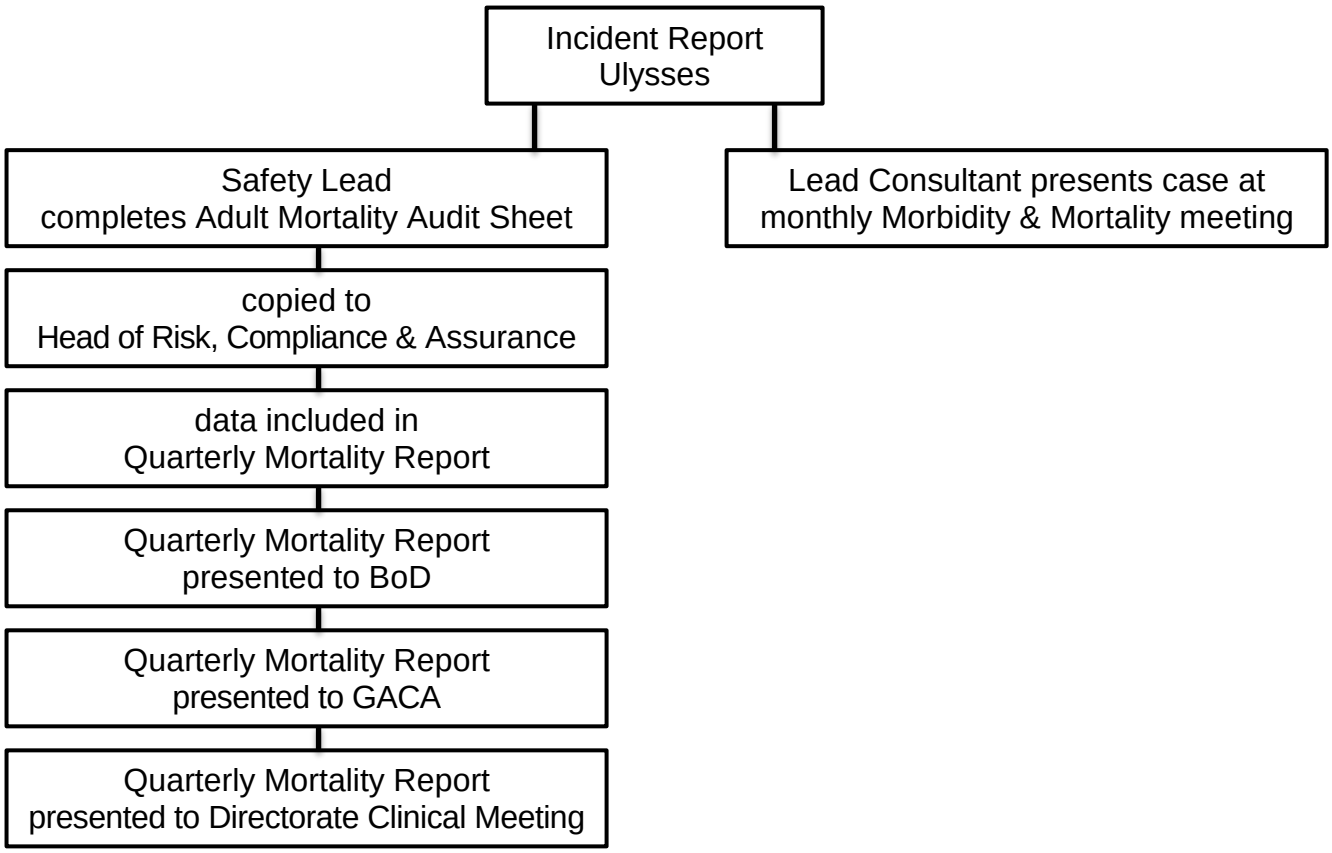
2. Learning, Candour and Accountability: a review of the way NHS trusts review and investigate the deaths of patients in England (December 2016). Available online at www.cqc.org.uk

3. National Guidance on Learning from Deaths. National Quality Board (2017) Available at www.england.nhs.uk

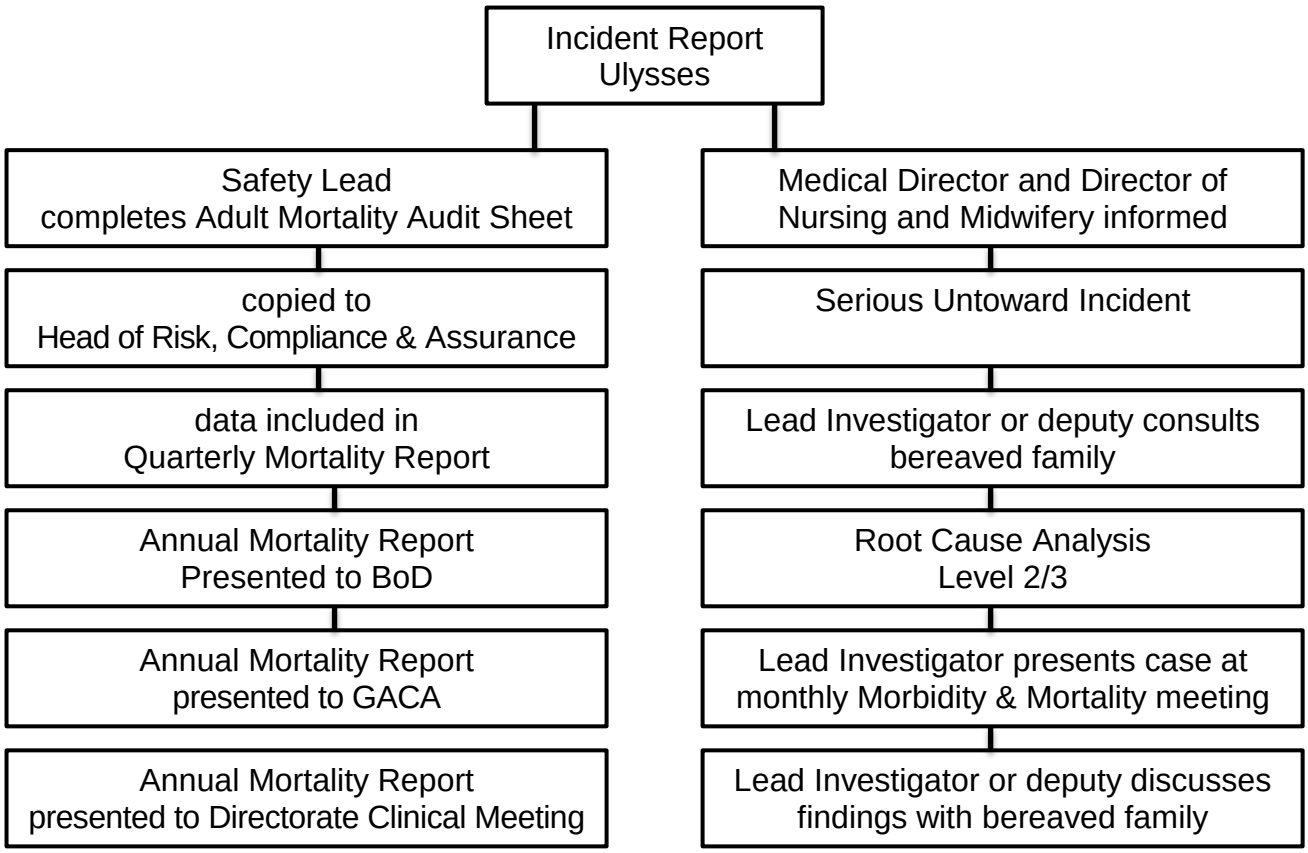
4. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. Hogan H et al (2012) BMJ Qual Saf 21, 737-745.

5. Learning Disabilities Mortality Review (LeDeR) Programme (2017) Available at www.bristol.ac.uk/sps/leder

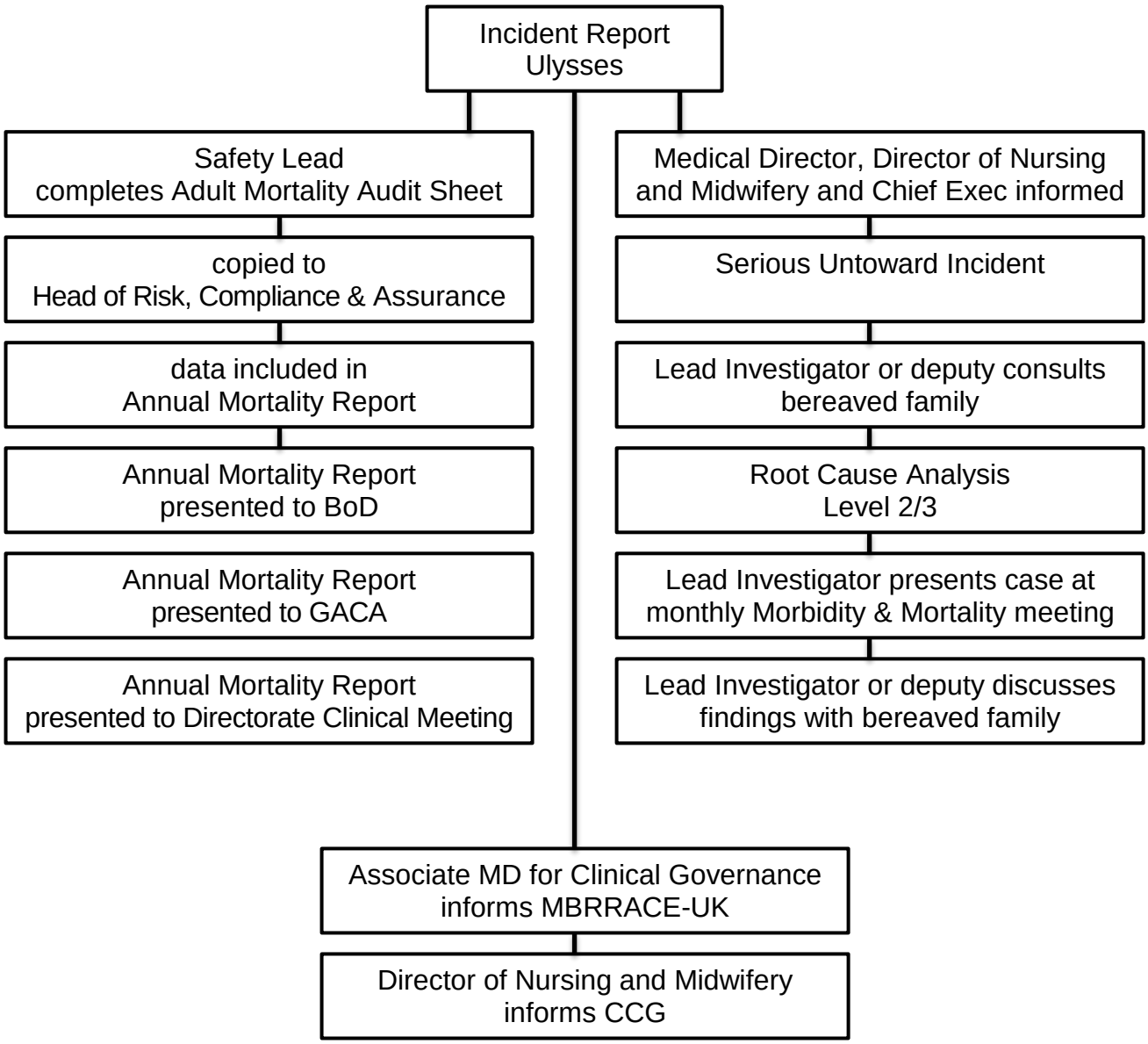
Appendix A: Response to an Expected Gynaecological Death



Appendix B: Response to an Unexpected Gynaecological Death



Appendix C: Response to a Maternal Death



Appendix D: Adult Mortality Audit Sheet

The content of the Adult Mortality Audit Sheet is as follows:

Date and time of admission:
Date and time of death:
Cause of death 1a: disease or condition directly leading to death
Cause of death 1b: other disease or condition if any, leading to 1a
Cause of death 1c: other disease or condition if any, leading to 1b
Cause of death 2: other significant disease or condition contributing indirectly to death
PM performed: Y/N
Documentation of DNAR in case notes: Y/N
Was the patient on an End of Life Care Pathway: Y/N
Did the patient receive any treatment prior to admission:
Was the patient seen in the emergency department prior to admission:
On initial clerking, were the history and examination appropriate: (If not, specify why)
Was the initial differential diagnosis appropriate: (If not, specify why)
Were the initial investigations (if any) appropriate: (If not, specify why)
Time of first review:
Number of hours after admission of first review:
Grade of doctor performing first review:
On first review, were the history and examination appropriate: (If not, specify why)
Was the differential diagnosis on first review appropriate: (If not, specify why)
Were the investigations on first review (if any) appropriate: (If not, specify why)
Time of first Consultant review:
Number of hours after admission of first Consultant review:
Was the NEW score recorded appropriately throughout:
Frequency of observations prescribed:
Clinical deterioration recognised:
Appropriate graded response to deterioration:
Clearly documented medical response to deterioration:
Did the deterioration result in cardiac arrest:
Did the patient receive CPR/resuscitation:
Did the separate location of LWH from an adult acute site contribute to the patient's death:
Did the separate location of LWH from an adult acute site reduce the quality of care provided: (If so, please specify)
Should the patient's management have been handled differently: (If so, please specify)
Are there any lessons to be learnt from this case: (If so, please specify)
Hogan scale:
1 definitely not preventable
2 slight evidence of preventability
3 possibly preventable but not very likely, a little less than 50/50
4 probably preventable but not certain, a little more than 50/50
5 strong evidence of preventability
6 definitely preventable
NCEPOD
1 good practice
2 room for improvement – some clinical care could have been better
3 room for improvement – some organisational care could have been better
4 room for improvement – some clinical & organisational care could have been better
5 less than satisfactory – several aspects of care below an acceptable level
How would you rate the overall quality of care provided by the trust: Excellent / Good / Adequate / Poor / Very poor
Please give a brief clinical resume of the patient:

Appendix E: Initial Equality Impact Assessment

Name of policy/ business or strategic plans/CIP programme:	**Adult Mortality Strategy v 1.0**	
Does the proposal, service or document affect one group more or less favourable than another on the basis of:	**No**	**Justification/evidence and data source**
Age	No	No discrimination / inequality identified, the document sets out the Trust's approach and framework for the management of Adult Mortality, ensuring this is systematic and objective and applied without prejudice or favour.
Disability: including learning disability, physical, sensory or mental impairment.	No	
Gender reassignment	No	
Marriage or civil partnership	No	
Pregnancy or maternity	No	
Race	No	
Religion or belief	No	
Sex	No	
Sexual orientation	No	
Human Rights – are there any issues which might affect a person's human rights?	**No**	**Justification/evidence and data source**
Right to life	No	No impact on human rights, the document sets out the Trust's approach and framework for the management of Adult Mortality, ensuring this is systematic and objective and applied without prejudice or favour. The aim being to reduce risks to the organisation, its services and the safety and well-being of patients, visitors, staff and the wider public.
Right to freedom from degrading or humiliating treatment	No	
Right to privacy or family life	No	
Any other of the human rights?	No	

Assessment carried out by: **Alan Clark**

Date:

Signature and Job Title:

Appendix F: Glossary and Abbreviations

Action	A response to control or mitigate a risk
Action Plan	A collection of actions that are specific, measurable, achievable, realistic and targeted.
Board Assurance Framework (BAF)	A matrix setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available
BoD	Board of Diorectors
Clinical Audit	A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit previously stated standards
Corporate Governance	The system by which Boards of Directors direct and control organisations in order to achieve their objectives
CQC	Care Quality Commission
Escalation	Referring an issue to the next appropriate management level for resolution, action, or attention
GACA	Governance and Clinical Assurance Committee
LeDeR	Learning Disabilities Mortality Review Programme
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
NHSLA	NHS Litigation Authority
NICE	National Institute for Health and Care Excellence
NPEU	National Perinatal Epidemiology Unit
RCOG	Royal College of Obstetrics and Gynaecology
Risk	The uncertainty of outcome of activity, described as the combination of likelihood and consequence, including perceived importance
Risk Management	The processes of identifying, assessing & judging risks, assigning ownership, taking actions to mitigate & anticipate them, monitoring and reviewing progress
Risk Register	A tool for recording identified risks and monitoring actions and plans against them
Strategy	A document that sets out the corporate approach to a particular area or work activity. This is sometimes described as a policy, particularly outside the NHS

Agenda Item	17/279

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Freedom to Speak Up – National Guardian Survey 2017**
DATE OF MEETING:	Friday, 06 October 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Michelle Turner, Director of Workforce and Marketing
AUTHOR(S):	Click here to enter text.
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 of Directors to*** • ***receive the Report & Recommendations of the National Freedom to Speak Up Guardian 2017; and*** • ***confirm they are sufficiently assured that the Trust has appropriate arrangements in place to support the role of the Freedom to Speak Up Guardian and actions in place to meet the recommendations of the National Guardian's Report 2017.***			
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

Last month (September 2017) the Board received the Speak Up Guardians Annual Report which set out the role of the guardian at the trust and the issues she addressed from December 2016 to July 2017.

The Report highlighted to the Board the importance of the role, which allowed staff to speak in confidence to the guardian without the feeling that she/he would be victimised for raising a concern. The success of the guardian role is due to the approachability of the guardian herself and the actions she takes to address concerns.

The Board was fully supportive of the role of the Guardian and noted that actions are being taken to address capacity concerns surrounding the pressures of juggling the role with that of her role as Head of Nursing and Operations for Gynaecology, Anaesthetics [and Genetics].

Report

Freedom to Speak Up – National Guardian Survey 2017

The requirement for Trusts and Foundation Trusts to have a Freedom to Speak Up Guardian in place came into effect in October 2016. The Trust had a Guardian in post prior to the formal requirement, having taken appointed to the role in April 2016.

The Guardian is a member of the Trust's Board Assurance Committee – Putting People First and also submitted her first full Annual Report to the Board in September 2017.

Dr Henrietta Hughes, the National Guardian for the NHS, has published a set of recommendations based on the findings of the first ever Freedom to Speak Up Guardian survey.

The National Guardian stated:

"Speaking up protects patients and improves the lives of NHS staff. Freedom to Speak Up Guardians provide an additional route for staff to raise issues, and support staff to do this every day. However, they need sufficient time to enable them properly to meet the needs of the workers they support. NHS leaders should provide that time as an investment in their staff. The survey shows that great strides are being made in speaking up but the picture is not consistent and there is still more to be done. I would like these recommendations to help improve the consistency and quality of support for speaking up in all NHS trusts and foundation trusts. I hope that senior leaders will welcome this report and I look forward to repeating this exercise next year."

The survey revealed some positive trends, including:

- nearly 9 out of 10 guardians are communicating their role internally
- over 8 out of 10 guardians feel supported by their senior management teams and Chief Executives, with only 3 in 100 feeling that they don't get this support
- 7 out of 10 guardians say that their organisations are actively tackling barriers to speaking up.

The National Guardian's Report identifies some key findings and recommendations for Trust's action. The Trust's current position against each of the recommendations of the report is attached to provide assurance that the Trust has effective arrangements in place for the Freedom to Speak Up Guardian and to promote the raising of concerns within the organisation.

Recommendation

The Board of Directors to

- receive the Report & Recommendations of the National Freedom to Speak Up Guardian 2017; and
- confirm they are sufficiently assured that the Trust has appropriate arrangements in place to support the role of the Freedom to Speak Up Guardian and actions in place to meet the recommendations of the National Guardian's Report 2017.

Michelle Turner
Director of Workforce
27 September 2017

National Freedom to Speak Up Guardian Review - Key findings and recommendations		Liverpool Women's Position /Action
APPOINTMENT	We recommend that appointment of guardians is made in a fair and open way, and that senior leaders assure themselves that workers throughout their organisation have confidence in the integrity and independence of the appointee.	Guardian role advertised with open competition, interview and selection process.
POTENTIAL CONFLICT OF INTERESTS	We recommend that all guardians / ambassadors / champions reflect on the potential conflicts that holding an additional role could bring and that they devise mechanisms to ensure that there are alternative routes for Freedom to Speak Up matters to be progressed should a conflict become apparent when supporting someone who is speaking up. We see particular potential for conflicts to arise where a guardian also has a role as a human resources professional and recommend that guardians do not have a role in any aspect of staff performance or human resources investigations.	Current Guardian is also Head of Nursing & Ops for Gynaecology. Potential risk for conflict acknowledged and addressed by decision to appoint a second Guardian. Currently out to advert. See above
LOCAL NETWORKS	We recommend that all trusts consider developing a local network of ambassadors / champions, depending on local need, to help provide assurance that all workers have appropriate support and opportunities to speak up, and to give guardians alternative routes to pursue speaking up matters should they be faced with a real or perceived conflict. Members of a local network could also cover the guardian role when the guardian is absent, on leave etc.	Trust has a newly recruited cohort of Dignity @ Work Advisers who will be given appropriate training to support staff who wish to raise concerns and act as a network for the Guardians
DIVERSITY	We recommend that all trusts take action to ensure that all workers, irrespective of their ethnicity, age, sexuality or other diversity characteristics, have someone they feel able to go to for support in speaking up. Guardians should consult with relevant representative groups in developing their approach on this matter. Guardians should also take action to assure themselves that any potential barriers to speaking up that particular groups face are understood and tackled.	Actions to be identified by the Diversity & Inclusion Committee in partnership with the Guardian to gain assurance and identify any barriers faced by any particular group

COMMUNICATIONS & TRAINING	We recommend that all guardians use all appropriate communication channels to ensure that all staff know of their role, and work with colleagues to ensure that Freedom to Speak Up is incorporated in all relevant staff training and development programmes, and particularly in staff inductions. In conjunction with the relevant parts of their organisation, guardians should monitor the effectiveness of their communication and training activities. Guardians should ensure that the language and message of communications and training are consistent with national guidance.	Guardian role well promoted through regular communications, posters, postcards, induction, leadership programme and regular walkabouts and attendance at team meetings by Guardian Guardian KPIs developed and monitored.
PARTNERSHIP	We recommend that all guardians continue to develop working partnerships with all relevant parts of their organisation.	Guardian has active rolling programme of engagement with teams and services across the organisation
ACCESS TO SENIOR LEADERSHIP	We recommend that all guardians have direct and regular access to their chief executive and non-executive director with responsibility for speaking up.	Guardian can directly access the CEO. Has regular meetings with Director of Workforce Has access to the Senior Independent Director.
LOCAL NETWORKS	We recommend that guardians or a representative from a local network of champions / ambassadors personally presents regular reports to their board. Board reports should include measures of activity and impact and, where possible, include 'case studies' describing real examples of speaking up that guardians are handling.	Guardian's Annual Report presented to Board in September 2017. Guardian now to attend Board of Directors twice a year. Guardian a full member of the Board Assurance Committee – Putting People First
FEEDBACK	We recommend that guardians always gather feedback on their performance, from their line managers, the partners they work with, and from those they are supporting.	Formal feedback process to be developed and included in Annual Reporting process.
TIME	We strongly recommend that all trusts provide ring-fenced time for anyone appointed as a guardian	Currently no ring fenced time but an additional £ allowance paid. To be reviewed with Guardian to establish if ring fenced time is required.

Agenda Item	17/280

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safeguarding Annual Report 2016/17**
DATE OF MEETING:	Friday, 06 October 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Doug Charlton, Director of Nursing and Midwifery
AUTHOR(S):	Mandy McDonough, Associate Director of Safeguarding Children and Adults
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:	
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:-….)***	***To receive an overview of safeguarding practice across the Trust and receive assurance that systems and processes are in place to protect vulnerable Children and Adults***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Governance and Clinical Assurance Committee	
	Date of meeting		Monday, 18 September 2017	

Executive Summary

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

Safeguarding is a fundamental component of all care provided within Liverpool Women's NHS Foundation Trust (LWFT) and as Safeguarding vulnerable people is a complex process; this year again has been both exciting and challenging in respect of ensuring that we respond effectively and efficiently to the challenges of safeguarding both our patients and staff.

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

This year, the continued progress and reputation of the Safeguarding Service has led to recognition from other provider Trust's and in June 2017, the Team were commissioned by Aintree Foundation NHS Trust to complete a Safeguarding Peer Review, in preparation for a CQC Inspection and in July 2017 a review of the Safeguarding Service for Wrightington Wigan & Leigh NHS Foundation Trust.

Much has been achieved over the past 12 months, with this annual report reflecting only the key safeguarding activities and achievements for children and adults for the period 01 April 2016 to 31 March 2017 and a synopsis of the objectives for future development, incorporating the work of the Safeguarding Team, supported by the Hospital Safeguarding Board.

The report provides the Board of Directors with assurance the Trust has effective systems and processes in place to safeguard patients who access services in the Trust and demonstrates the Trust is meeting its statutory responsibilities in relation to safeguarding.

Over the coming year the Safeguarding Team have identified several priorities, which are outlined in the report, all of which are central to supporting core activities to safeguard children and adults.

Board Approval

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

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

Dr Doug Charlton
Executive Director of Nursing & Midwifery / Director for Safeguarding

Report

Contents

1. Introduction

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

The purpose of this document is to provide an overview of Safeguarding activity within the Trust for the period 1st April 2016 – 31st March 2017.

'Safeguarding Mission Statement'

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

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

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

Effective communication and timely intervention is fundamental to safeguarding patients. The Team strive to improve this through:

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

The Trust Safeguarding Team have effectively integrated and implemented relevant processes and recommendations in conjunction with continuing financial austerity and change across other partner agencies.

Maintaining the function and quality of all aspects of safeguarding practice across the Trust has been essential and a particular focus has been on ensuring effective

strategic Safeguarding leadership was in place, establishing robust governance and assurance processes and developing an effective Safeguarding Strategy.

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

2. Summary of Current Position

2.1 Safeguarding Specific Objectives for 2016-2017

Throughout the reporting period for 2016/17, significant progress has been made with the safeguarding adults and children's work plans and our overall objective's, which were to:

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

In order to provide the assurances required to demonstrate our objective's, the following has been achieved:

Objective	Progress	RAG
Ensure all Trust staff has the appropriate skill set and understanding to Safeguarding LWFT patients and staff	1. The organisation is linked into the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adult Board (SAB) 2. A programme of internal audit and review is in place that enables the organisation to continuously improve the protection of all service users from abuse or the risk of abuse. 3. Staff working directly with vulnerable adults and children have access to advice support and supervision. This includes clinical and safeguarding supervision. 4. Training Strategy review ensuring staff are trained and given the appropriate skill set and understanding to their role around safeguarding.	

The organization to ensure that the child's voice is heard and has an impact on service development and improvement	1. There is a process for ensuring that patients are routinely asked about dependents such as children, or about any caring responsibilities 2. There is evidence that the voice of the child is incorporated within all routine and targeted health assessments, with particular focus on LAC, CPP and CIN/CAF assessments	
Ensure there is a culture of listening and learning within the organisation	1. There is a process which allows feedback clearly showing the views of the child/families 2. Lessons learnt from Serious Case Reviews / Individual Management Reviews are disseminated across the organisation 3. Practitioner forums /Staff Open Days / Training events and Staff Surveys to allow staff input in to processes	

3. Risk, Performance, Governance and Assurance

3.1 Risk

3.1.1 Board Assessment Framework (BAF)

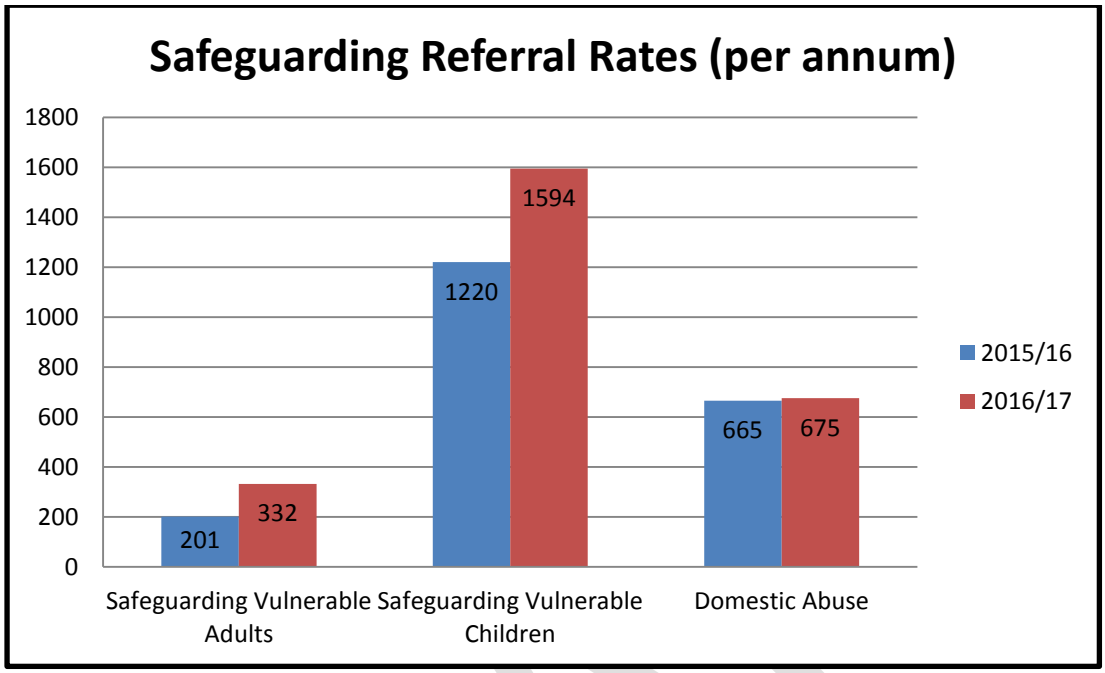
There was one risk on the Trust BAF (1732) which was monitored by the Hospital Safeguarding Board (HSB). This was originally scored as a 20, however due to the completed progress in the Safeguarding Service the score has been reduced to 15 and furthermore to 9 and now sits on the Safeguarding Service risk register.

3.1.2 Safeguarding Risk Register

Risk item 1895, scored at 9, continues to be monitored by HSB with two outstanding actions. The actions are remaining whilst awaiting external agency input to complete.

3.2 Performance

3.2.1 Safeguarding Performance Data



3.2.2 Clinical Commissioning Group (CCG) Key Performance Indicator (KPI) Reports

In April 2017, the CCG confirmed significant assurance with the Trusts Safeguarding Service as part of their Annual Report.

In keeping to the approved strategy and work plans developed from the identified strategic risk (item 1732), progress has continuously been made within the last 12 months to increase compliance, this progress has been most notable in the following areas:

1. Safeguarding Supervision
2. Partnership working
3. Looked After Children
4. Early Help Agenda
5. Voice of the Child

3.2.3 Local Safeguarding Children Board (LSCB) Section 11 Audit

Section 11 of the Children Act (2004) places duties on a range of organisations and individuals to ensure their functions and any services that they contract out to others,

are discharged having regard to the need to safeguard and promote the welfare of children.

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

Following the submission in 2015/16, LWFT have continued to update the system throughout the year ensuring Section 11 compliance and accurate recording. All information has been made available to Liverpool, Sefton and Knowsley Safeguarding Boards.

In March 2017, Sefton's Safeguarding Children's Board, Performance and Quality Audit Sub Group visited LWFT to review evidence submitted in the areas we had indicated as fully compliant in the Section 11 Self-Assessment. As part of that visit, the Board were able to see and discuss the evidence for the self-assessment score including all relevant data and policies which evidenced our compliance. The visit resulted in 'significant assurance' being provided from Sefton's Safeguarding Children's Board.

3.2.4 Merseyside Safeguarding Standards Annual Audit

As part of the Annual Audit submission requirements, in October 2016, LWFT submitted their self-assessment against the Merseyside Safeguarding Standards. To date LWFT have not received feedback to this submission from the CCG and have escalated it to the Clinical Quality and Performance Group (CQPG).

3.3 Governance

3.3.1 Policies

Following publication of updated legislation and national guidance, LWFT ensures all safeguarding policies are compliant and accurate. The Trusts policy is to ensure policies are reviewed every 3 years, however, Safeguarding policies are reviewed every 12 months due to the regular changes in guidance and law.

3.4 Assurance

3.4.1 Hospital Safeguarding Board (HSB)

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

The HSB Terms of Reference include representation from the Designated Nurses (CCG), Non-Executive Director (Safeguarding Champion) and is chaired by the Director of Nursing and Midwifery. The Board provides strategic overview and scrutiny across all aspects of Safeguarding.

In the last 12 months, the HSB has focused on monitoring progress with CCG compliance and engagement with external partners.

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

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

3.4.2 Safeguarding Operational Group (SOG)

The Safeguarding Operational Group (SOG) supports the HSB, Its primary purpose being to ensure that safeguarding children and adults is a Trust wide priority. In 2016/17, through monitoring compliance with training, incident trends, Safeguarding Inspection Reports, Serious Case Review findings and Safeguarding performance and activity; the group have provided assurance to the HSB that safeguarding arrangements within the Trust are compliant with appropriate legislation and national/local guidance in respect of Safeguarding Children. Due to a noted increase in assurance, the meetings are now quarterly.

4. Training

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

Session	CCG Compliance Threshold (%)	Compliance as of April 2017 (%)
Safeguarding Children Level 1	90%	**93%**
Safeguarding Children Level 2	90%	**93%**
Safeguarding Children Level 3	90%	**93%**
Safeguarding Children Level 4	90%	**100%**
Safeguarding Adults Level 1	90%	**93%**
Safeguarding Adults Level 2	90%	**93%**
Safeguarding Adults Level 3	90%	**92%**
Safeguarding Adults Level 4	90%	**50%***
MCA & DoLS (Advanced)	90%	**93%**
Prevent (Basic Awareness)	90%	**93%**
Prevent (WRAP)	70%	**63%**

*New Named Doctor for Safeguarding Adults in post has reduced our compliance. Training booked for September 2017.

Due to the current developing safeguarding legislative requirements and to provide assurance our staff are trained appropriately, the Safeguarding Training Strategy received a full review in 2016.

5. Safeguarding Children

Working Together to Safeguard Children (2015)' sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Children Act 1989 and the Children Act 2004.

All providers of NHS health services, including Foundation Trusts are required to identify a Named Doctor, Named Nurse and a Named Midwife (if the organisation provides maternity services). LWFT supports the statutory requirements for Safeguarding Children with the roles of the Associate Director of Safeguarding who is the Trust's Named Nurse and Midwife for Safeguarding Children and Dr Chris Dewhurst who is the Named Doctor for Safeguarding Children.

5.1 Serious Case Reviews (SCRs)

Working Together to Safeguard Children (2015) sets out very specific criteria for conducting SCR's. A SCR is undertaken by a Local Authority Board appointed Independent Author when a child dies, or is significantly harmed and neglect is known and/or suspected to be a factor in the case. The purpose of the review is to establish whether lessons can be learned with regard to how professionals and organisations work together to safeguard and promote the welfare of children and formulate action plan's to improve intra-agency working.
During this reporting period the Safeguarding Team have had no direct involvement in any new Serious Case Review's.

The Safeguarding Team regularly review the Safeguarding Training and include the findings from local and national SCR's. To embed the learning, the Team deliver a one hour 'lessons learnt' training session, bi-monthly in conjunction with our Learning and Development Department.

5.2 Child Sexual Exploitation (CSE)

Recent high profile cases in the UK (Rochdale, Rotherham, Oxfordshire and Wirral) have highlighted health services significant contribution in the identification and response to cases of sexual exploitation. As such, NHS England has recognised CSE as a national priority for all health staff and agencies.
The Pan Merseyside/Cheshire Child Sexual Exploitation Multi-Agency Strategy (2014 -2017) sets out agency responsibilities in the identification of young people who use our service. To ensure staff are aware of how to recognise young people potentially at risk and know how to refer them as appropriate, the following has been put in place:

- All LWH receive CSE Training in their Mandatory Level 1and 2 Training; Safeguarding Children Level 3 and Adults Level3
- Staff in high risk areas such as ED and Bedford Clinic have a 'checklist' to help them identify vulnerabilities and behaviours which might be indicative that a young person might be at risk of CSE
- Following the recent Joint Targeted Area Inspection (JTAI) in Liverpool, all CSE referrals are discussed in the Multi Agency Safeguarding Hub (MASH) and then shared with the Trust in order to undertake any additional information requests and 'flag' on our Bulletin Board

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

5.3 Voice of the Child

The failure to listen to children and ensure their views are taken into account in child protection cases has been highlighted in many Serious Case Review findings. For this reason, the Working Together to Safeguard Children (2015) guidance recommends the development of local protocols to actively involve children in the child protection process.

This is difficult to embed in a provider organisation which predominantly delivers healthcare to women and babies; although we recognise some of our patients may be under 18 years of age. In terms of reducing risks and achieving better outcomes for children at risk, this area of work was identified by the Safeguarding Team as needing to work in conjunction with our external / partner providers with.

5.4 Looked After Children (LAC)

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

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

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

Healthcare services and related organisations who work with children and young people have a responsibility to keep children safe. A number of LAC access the Trust on a regular basis via the Emergency Room, Bedford Clinic, Gynaecology and Maternity services. On each occasion staff are asked to notify the Safeguarding Team of this young person's admission or attendance. .

Due to the nature of safeguarding, there is a large number of new born babies who are made subject to Interim Care Orders while present in the hospital and are discharged to Foster Care, Parents or other services. Further to this babies may leave the hospital after their parents have signed an agreement for the Local Authority to accommodate their child while further assessments are undertaken. On all of these occasions a copy of the Care Order or agreement is placed in the

patient's notes and a member of the Safeguarding Team will assist staff with the often emotional and challenging nature of removing a new born baby.

6. Safeguarding Adults

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

Significant progress has been made this year in raising awareness with all staff groups, through the delivery of the Safeguarding Training Strategy, of their role in responding to the needs of those adults vulnerable to abuse. However, there have been minimal referrals to Social Care in respect to allegations of abuse against adults.

It is felt that the tertiary nature of the Trust combined with the limited numbers of adults with dementia, learning disabilities and complex needs, may be a contributory factor in the low referral rate. This is similar for other specialist Trusts, compared to the referral rate in that of an acute adult services provider.

The Safeguarding Team have continued to build upon the work already accomplished, endeavouring to increase the identification of potential abuse and referrals as well as continued to work collaboratively with external partners in safeguarding those adults most vulnerable to abuse.

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

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

In August 2015, an audit of compliance with the Mental Capacity Act 2005 (MCA) found that none of the cases met the required legal standard. In response a the following recommendations were made:

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

All recommendations were agreed and embedded in practice by the end of 2015 and compliance was re-audited in April 2016.

It was identified that all patient notes audited, met the legal standard required with regard to both capacity assessments and best interest decisions.

6.2 Learning Disabilities & Dementia

In discussion with partner agencies following the introduction of the Dementia Strategy across Liverpool in 2012; it was agreed that, due to commonalities in strategic and operational approach, the Trust would combine both the care of patients with dementia and those with learning disabilities into a joint strategy that provides the required statutory and contractual assurance.

.

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

7. Domestic Abuse

Domestic abuse is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

This can encompass, but is not limited to:

- Psychological, physical, sexual, financial and emotional abuse

- Controlling behaviour - a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour

- Coercive behaviour - an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage,

As many victims are afraid of reporting abuse and/or violence to Police, identification of high risk victims of domestic abuse has been made possible by the use of a risk identification tool. These identified victims are discussed at a Multi-Agency Risk Assessment Conference (MARAC), which is a core group, representing both the statutory and voluntary sector.

The aim of a MARAC is to allow for maximum information sharing between relevant agencies within an agreed protocol. It allows for the agencies to identify those most at risk from violence and abuse and thereafter jointly construct a management plan to provide a professional, co-ordinated approach to all reported incidents of domestic abuse.

The Trust is required to provide health information relevant to the cases being discussed for all MARAC meetings and attend the meetings where victims who are referred by the Trust, are discussed.

In 2016/17 the MARAC/LWFT internal processes were reviewed by the Trust Safeguarding Service following an internal audit of performance against the Domestic Abuse Policy. As such, we have now introduced the 'Domestic Abuse (CAADA) National Risk Assessment Tool', used by other health providers and continue to work in collaboration with our external statutory partners to ensure there is a robust response to women identified to us as subject to any form of domestic abuse.

7.1 Domestic Homicide Reviews (DHRs)

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

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

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

LWFT have been involved in the completion of one DHR's chronology in this reporting period. In this case there were no recommendations or poor practice points identified for the Trust.

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

The 'Protecting Vulnerable People Agenda' remains a priority for Liverpool. As such, some preparatory work has already been undertaken by the Office of the Police and Crime Commissioner and Police, looking at the Strategic Governance required. in This work has been in consultation with statutory partners and voluntary sector and LWFT's Associate Director of Safeguarding has represented the Trust in the completion of this.

The review has led to the formation of the Harmful Practices Group. As well as developing an agreed Pan-Merseyside Policy, this group will raise awareness among professionals and practitioners of harmful practice such as Forced Marriage, Honour Based Violence and Female Genital Mutilation. This work is ongoing.

7.3 Human Trafficking / Modern Slavery

In 2016/17, the Safeguarding Team were involved with a number of cases of modern slavery and human trafficking; also known as Serious & Organised Crime threats
.
On average the Safeguarding Team receive 1 or 2 referrals per week for women who disclose they have been trafficked. The referral process from the Trust to the Local Authorities and the Home Office, often results in limited feedback regarding the management of the case.

To be better able to identify and understand the potential issues and any operational opportunities to tackle it, the Associate Director of Safeguarding has met with the Assistant Chief Constable (ACC) for Merseyside Police who leads the North West Regional Organised Crime Unit (NWROCU) also known as 'Titan'.

Titan has responsibility for a wide range of issues, of which includes Modern Slavery, Child Sexual Exploitation and Organised Immigration Crime. A key benefit of joint working with Merseyside Police will be access to operational data and intelligence. This will enable clearer identification of individuals and groups involved, allowing for opportunities to disrupt, prevent and prosecute those responsible; and ultimately safeguarding vulnerable victims as appropriate.

8 Safeguarding Supervision

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

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

Following a review of the Trusts Safeguarding Supervision policy in October 2015, the Trust sourced a training course from the National Society for the Prevention of Cruelty to Children (NSPCC) to allow key staff to provide Safeguarding Supervision. As such, the organisation is discharging its duties and responsibilities for Safeguarding Supervision.

9 LWFT Safeguarding Peer Review

During this reporting period the Associate Director of Safeguarding Children and Adults (LWFT), undertook a review at the request of Aintree University Teaching Hospital NHS Trust and Wigan, Wrightington and Leigh NHS Foundation Trust's Safeguarding Services.

Both Trust's commissioned the review as part of their work towards a state of preparedness for a Care Quality Commission (CQC) thematic inspection as it was felt a review of this nature would add value to the improvement journey of safeguarding within the individual Trust's. By providing an overview, position statement and assurance they are now able to prioritise key actions and accelerate improvement and further development.

Reports detailing the key findings from the reviews, making a number of recommendations for the consideration of the Executive Team have now been completed. Although a substantial amount of work, the reviews have allowed the Trust's to share best practice and generated substantial future joint working opportunities for all.

10 Safeguarding Team Future and Potential Structure

Since the Safeguarding Service review completed in 2014, the processes and structure within LWFT safeguarding service has changed in order to ensure compliance with the safeguarding standards expected of a safeguarding service within a specialist Trust.

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

The current structure provides the appropriate skill mix and expertise within the team to enable them to deliver a robust service, accessible to frontline staff. The competencies and experience held collectively within the Team, such as a Children's Social Worker, Midwifery and Nursing staff, a Best Interest Assessor and a member of staff who have specialist knowledge of the safeguarding governance and assurance processes; enhances the effectiveness of the service, as the staff have the confidence and expertise in decision making within their chosen field. This has also allowed for resilience between the roles to ensure that clinical capacity and relevant core and specialist clinical competence within the service is not reduced, resulting in no compromise to the productivity of the service in fulfilling its statutory and clinical responsibilities.

As in 2015/16, the skill mix and experience within the Safeguarding Team has again this year enabled the Team to complete Safeguarding Peer Reviews for other providers, in preparation for their Themed CQC Inspections; and enabled the Team to continue to build on marketing their excellent service with its robust, efficient and effective model of safeguarding practice.

Moving forward, as LWFT Safeguarding Team have best placed for some time now to build on these foundations and lead on a safeguarding service across other providers; working in conjunction with Aintree University Hospital NHS Foundation Trust's (AUT) Chief Nurse and LWFT's Director of Nursing and Midwifery, the Team are in the process of developing a shared Safeguarding Service across both sites.

While discussions around this service are ongoing, interim arrangements for the management and provision of a comprehensive Safeguarding Service have been made for the next 6 months, under the terms of a Service Level Agreement (SLA) between LWFT and AUT.

Under the Terms of the Agreement, the Authority (LWFT) will provide the following key personnel to AUT:

- Associate Director of Safeguarding for Children & Adults / Named Nurse and Midwife for Safeguarding Children (0.6 WTE)

- Named Nurse for Safeguarding Adults / Lead for MCA & DoLS / LD & Dementia (0.8 WTE)
- Safeguarding Manager / PREVENT Lead (0.6 WTE)

Initially this work will be a scoping exercise of the organisational processes and performance; including data flow internally and externally, patient demographics, Safeguarding Team structure, policies and training requirements. Based on recent inspection reports and KPI's, an agreed work plan that sets out the key objectives identified with an accompanying trajectory for the identified priorities.

11. Key Objective for 2017-18

2016/17 has again been a year of significant activity and scrutiny, throughout which the Trust has demonstrated that there are robust mechanisms in place to safeguard adults, young people and children from abuse.

As approach's to safeguarding continually evolve and the complexity of decision making increases around newly recognised forms of harm and abuse, the current structures and process will continue to develop in response. Aside from further embedding of existing overall process, key areas / objectives for improvement have been identified in the priorities for 2017/18:

- Through continued collaboration between the Local Authority, Police and other services and external partners; further develop and implement improvements in the quality and provision of services for children, young persons and adults to ensure that safeguarding practice and procedures are adhered to and compliant with National and Local standards, primary legislation, Government guidance and strategy

- Provide expert advice and strategic direction to Aintree University Hospital NHS Foundation Trust Chief Executive, Board of Directors, Director of Nursing, Managers and Clinicians as required on Safeguarding in accordance with National and Local policy and in the best interest of the reputation of the Trust; and ensure the provision of assurance relevant to Safeguarding, to the Hospital Board

- Ensure a close working relationship with commissioners and external agencies/partners for both Liverpool Women's NHS Foundation Trust and Aintree University Hospital NHS Foundation Trust regarding service design and delivery relating to safeguarding issues; and including provision of quarterly Key Performance Data (KPI's)

- Building on an established Safeguarding Team and processes, compliant with legislation, within Liverpool Women's NHS Foundation Trust; further develop the collaborative vision for safeguarding across provider organisations

Agenda Item	17/281

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Patient Led Assessment of the Care Environment (PLACE) Assessment 2017**
DATE OF MEETING:	Friday, 06 October 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Doug Charlton, Director of Nursing and Midwifery
AUTHOR(S):	Linda Martin, Patient Facilities 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 **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:-….)***	***To receive the results of the 2017 PLACE Assessment.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	GACA		
	Date of meeting	18 September 2017		

Executive Summary

The Trust PLACE Assessment was carried out on Wednesday 5th April 2017. The results were published nationally on 15th August 2017.

The Board is asked to receive and note the contents of the report.

Report

1. Introduction and summary

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

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

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

Organisations are assessed in the following categories:

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

The Trust PLACE Assessment was carried out on Wednesday 5th April 2017. The results were published nationally on 15th August 2017.

The following table details how the Trust 2017 results compare to the 2017 national results and to 2016 Trust's results.

	Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition, Appearance and Maintenance	Dementia	Disability
Liverpool Women's 2017 results	**99.89%**	**88.87%** (Organisation 80.66% Ward food 94.79%)	**77.84%**	**94.75%**	**72.71%**	**74.90%**
National Average 2017 results	98.38%	89.68% (Organisation 88.80% Ward food 90.19%)	83.68%	94.02%	76.71%	82.56%
Liverpool Women's 2016 results	99.96%	89.79% (Organisation 78.51% Ward food 94.95%)	78.35%	94.90%	83.48%	78.15%

The Patient Facilities Manager managed the process which included a team of patient representatives, governors, volunteers, matron, housekeepers, infection control nurse and an external assessor from the Royal Liverpool & Broadgreen Hospital.

2. Issues for consideration

Cleanliness
99.89% The Trust scored above the national average and but slightly lower than last year. This was due to the building works being carried out on the second floor – some evidence of dust was reported.

Food (Organisation Food & Ward Food)
88.87% The Trust scored lower than the national average and lower than 2016 scores. In the main this was due to not being able to serve the evening meals to patients at the later time of either 5.30pm or 6.00pm. However, the Trust piloted a later meal service of 5.30pm but the feedback from patients and staff was that this coincided with visiting times and other ward activities – the suggestion was made to change the start time of the evening meal service to 5.00pm – previously it had bene 4.45pm. The new time of 5.00pm now applies to all wards which should improve the scores in 2018 but will not attract the highest score available.

Privacy, Dignity and Wellbeing
77.84% The Trust scored lower than the national average and slightly lower than in 2016. Factors contributing to this were introduction of wellbeing questions around availability of individual TV's, facility to have meals away from their beds if patients choose to do so and some reception desks do not provide sufficient distance away from others when discussing personal details. With the introduction of the self check in system and the new outpatients' reception area it is expected that these results will improve in 2018.

Condition, appearance and maintenance
94.75% The Trust scored above the national average but slightly lower than in 2016. At the time of the assessment there was a considerable amount of refurbishment works being undertaken on the ground and second floors. These works are now complete and provide a much improved outpatients area and Gynaecology ward and therefore, it is anticipated that this score will be improved in 2018.

Dementia
72.71% The Trust scored below the national average and below its score in 2016. Again the refurbishment works had an impact on this category with many temporary signs in place, main entrance being used as Gynaecology Outpatient's waiting area and the Gynaecology ward split in two.

Disability
74.90% The Trust scored below the national average and lower than in 2016. Again the temporary signage and main entrance being used as waiting area for clinic appointments contributed to the lower scores, plus the absence of hand rails in some areas.

Other comments

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

- ***Lots of space for private thought.***
- ***Tea Bars and water dispensers in Outpatients and other clinics.***
- ***Tea and coffee making facilities in wards.***
- ***A modern building with good cleanliness, well maintained and where patients are treated with dignity and respect.***
- ***Food of exceptional quality and patients had input into the choice of food on offer***
- ***Room eight on delivery "bereavement room" was exceptional.***
- ***Friendly and helpful staff.***

3. Conclusion

Generally, mainly good results and positive comments but with some reduction in results compared to 2016 largely due to the refurbishment works at the time of the assessment. Since the assessment the works have been completed and provide an enhanced environment for patients, staff and visitors which should be reflected in 2018 results.

The results will be published in all wards/clinics by end of October 2017.

4. Recommendations

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

Agenda Item	2018/282

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**
DATE OF MEETING:	Friday, 06 October 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.

Two incidents relating to staffing were reported during August related to Delivery Suite. 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 continue to highlight the good practice of reporting medication errors especially in the neonatal unit. All errors are investigated and appropriate action taken. No error resulted in harm to any patient. Four complaints were received during August relating to the Maternity Service which were investigated and responded to within the specified timeframe.

Care hours per patient day remain at a sustained level indicating a consistent level of nursing/midwifery resource to provide care to our patients.

Bank staff usage was higher in August than in previous months and was recorded above the set KPI of 6%; additional staff have been used to fill gaps in rotas due to vacancies. This should now resolve due to the recent midwifery recruitment drive.

Sickness levels remain above the set 3.5% KPI target at 6.0 %. The majority of reported sickness is due to long term sickness leave. All sick leave is actively managed by Matrons and Heads of Nursing /Midwifery

Staffing across the inpatient ward areas for August remained appropriate to deliver safe and effective 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 August 2017.

1.2 To provide context for the Trust Board on the UNIFY safe staffing submission for the month of August 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 August 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 - August 2017				
Ward	RN/RM		Non Registered		
	Fill Rate Day%	Fill Rate Night %	Fill Rate Day%	Fill Rate Night %	Total Workforce CHHPD
Delivery & Induction Suite	88.90%	86.50%	130.60%	84.90%	32.7
Mat base	88.70%	88.90%	81.30%	97.80%	6.3
MLU & Jeffcoate	86.00%	77.40%	93.50%	103.20%	36.8
NICU	114.10%	113.50%	75.80%	46.80%	13.8
Gynae Ward	99.30%	99.20%	93.10%	94.50%	9.1

Nurse Sensitive Indicators - August 2017									
Ward	CDT	MRSA	Falls No Harm (N)	Falls Harm (N)	HAPU grade 1&2	HAPU grade 3&4	Drug Admin error	New Complaints	Red Flags
Delivery & Induction Suite	0	0	0	0	0	0	0	1	23
Mat base	0	0	0	0	0	0	0	3	0
MLU & Jeffcoate	0	0	0	0	0	0	0	0	4
NICU	0	0	0	0	0	0	24	0	1
Gynae Ward	0	0	0	0	0	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 97.4 %for registered staff and 91.8 % for care staff during the day and 95.7.0 % for registered staff and 84.7 % for care staff during the night.

4.3 On the day and night shifts, three clinical areas (Delivery Suite, Mat Base & MLU) reported staffing below 90% fill rates for qualified Nurses/Midwives. One clinical area reported above 100% fill rate for Registered Staff (Neonatal) on day shift.

Day		Night	
Average Fill Rate	Average Fill Rate	Average Fill Rate	Average Fill Rate
Registered Nurses/Midwives	Care Staff	Registered Nurses/Midwives	Care Staff
97.4%	**91.8%**	**95.7%**	**84.7%**

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)

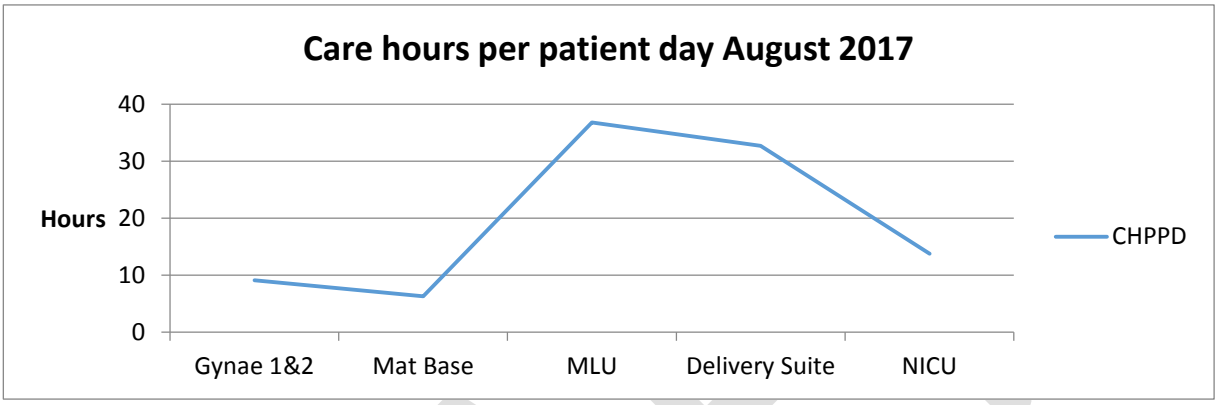
	Initial Red Shifts	
Ward	Number of shifts where staffing initially fell below agreed levels and reported using Ulysses	% of shifts where staffing fell below agreed levels and triggered a red rating
Delivery Suite	2	**2.2%**

6.1 Staff are encouraged to report any incident they believe may affect safe patient care using the Ulysses system. During August two reports was submitted relating to staffing on 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.

6.2 Analysing data for the last four months relating to staff reported incidents on staffing has determined no trends. Staffing concerns have been raised using the Ulysses system by staff in all clinical areas and these are investigated and rectified where possible by reallocating staff. The acuity of the patients and the bed capacity is taken in to account by Matrons when evaluating the issues raised.

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 (36.8 hours) and the Maternity Base have the least (6.3 hours). These data have remained consistent over the last four months.



7.2 This month's average recorded number of hours of Registered Nurse/Midwife time spent with patients was calculated at 10.9 hours and 2.5 hours for care staff. This provides an overall average of 13.4 hours of care per patient day.

	CHPPD
Registered Nurse/Midwife	10.9
Care Staff	2.5
Overall hours	13.4

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 care hours available to deliver care on our inpatient wards.

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

Ward Name	Aug-17	Jul-17	Jun-17	May-17	Apr-17	Mar-17	Feb-17
Gynae 1&2	9.1	9.9	8.5	7.0	8.1	7.0	7.2
Mat Base	6.3	6.0	6.4	5.9	6.4	6.0	6.5
MLU	36.8	42.0	38.1	40.4	42.4	37.0	35.4
Delivery Suite	32.7	33.1	34.3	26.8	36.5	31.3	31.5
NICU	13.8	12.6	11.8	10.5	10.1	11.2	12.3
Total CHPPD	**13.4**	**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 56 reported incidents against the Nursing staffing indicators for August. Of the incidents reported 24 related to medications in the Neonatal Unit.

8.3 There were 4 new complaints reported, one relating to delivery suite and three related to Mat Base.

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

Nurse Sensitive Indicators - August 2017									
Ward	CDT	MRSA	Falls No Harm (N)	Falls Harm (N)	HAPU grade 1&2	HAPU grade 3&4	Drug Admin error	New Complaints	Red Flags
Delivery & Induction Suite	0	0	0	0	0	0	0	1	23
Mat base	0	0	0	0	0	0	0	3	0
MLU & Jeffcoate	0	0	0	0	0	0	0	0	4
NICU	0	0	0	0	0	0	24	0	1
Gynae Ward	0	0	0	0	0	0	0	0	0

8.5 28 Red Flags were identifed during August, 23 on Delviery Suite, 4 on Mat Base and 1 on the Neonatal Unit. A list (for informaiton) of the type of incidnets is provided below. All red flags are investgated by the Matrons and remedial action where necessary to ensure safe patinet care. A detailed report of these incidnets are reviewed at the Nurisng & Midwifery Board monthly.

Midwifery Red Flag Events:

- Delay or cancellation of activity
- Wait for more than 60 mins for sutures post delivery
- More than 30 minutes wait for midwife review whilst in labour
- Full examination when in labour not provided
- Delay in spotting and escalating ill health
- Delay >2 Hours Between Admission And Induction
- Delay >30 mins Between Presentation And Triage
- 1:1 Support Not Provided During Established Labour
- Delay of more than 30 mins for analgesia
- Medication Error - Drug not given

Nursing Red Flag Events:

- Unplanned omission of medication
- Delay of more than 30 minutes for analgesia
- Vital signs not recorded as care plan
- Comfort rounds not undertaken
- Less than 2 registered nurses on during shift
- Shortfall in staffing

8.6 Neonatal Medication Errors Explained

A medication error taskforce report is presented at the regular Neonatal MDT meeting and at the Medicines Management Committee which details the types or errors which have been reported and the actions taken to ensure reoccurrence in these errors is minimised

8.6.1 Current Error rate

Each baby on the neonatal unit has approximately 16 drug administrations a day.

Running at approximately 40 babies on the unit this equates to:

- 640 drug administrations a day
- 19,200 drug administrations a month
- 76,800 drug administrations a quarter

On average 48 reported drug errors a quarter – this leads to a drug error rate of 1 error per 1,600 drug administrations (0.0006%).

All staff who report an error are supported to learn from that error and undertake a reflection for further professional development and learning. Should it be considered further training is required this is provided by the Education Team.

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.

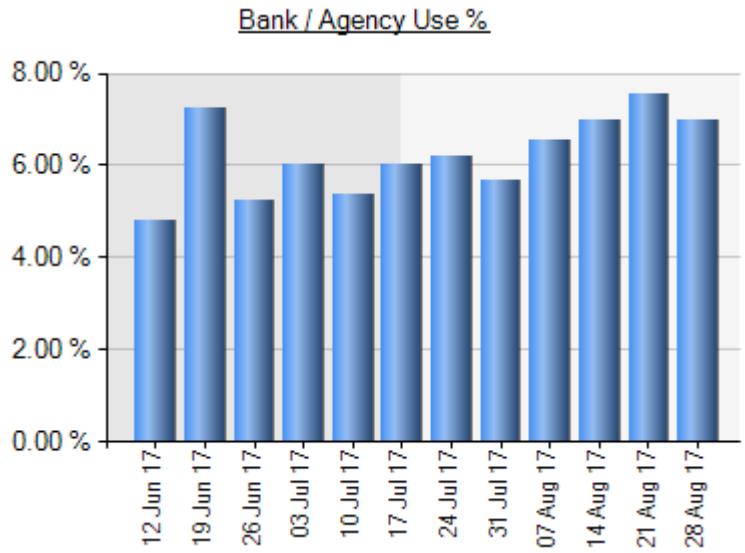
b) The process allows for an overview of the total number of temporary staff (bank) used in different clinical ward areas and provides a monitoring mechanism for the delivery of safe quality care.

10.0 Bank Usage Inpatient Wards (month ending August)

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 August (this is cumulative data captured from roster performance reports). No agency staff

were used to replace substantive staff.

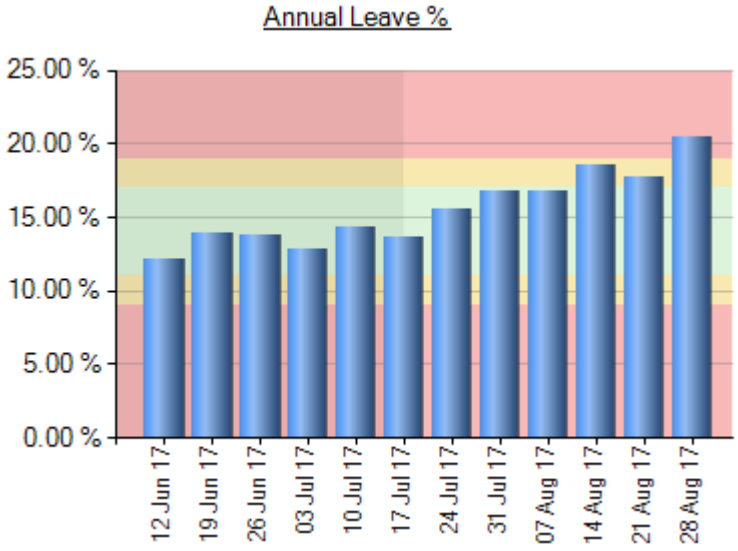
10.2 A key performance indicator (KPI) of less than 6% bank usage (bank shifts compared to total shifts assigned) was set to coincide with the NHS England agency cap. The percentage continues to fluctuate and has risen above the 6% target for August. This rise is due to a number of different reasons namely, short term sickness leave and vacant posts and it coincides with peak holiday season. It is anticipated next year the rotas will be managed in such a way as to prevent this occurring and the use of bank staff should reduce.



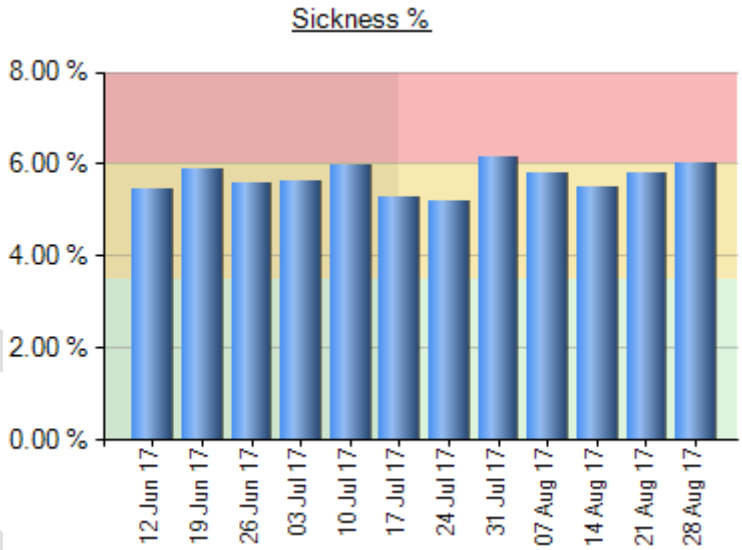
11.0 Managing Staff Resource

11.1 Annual leave taken during August 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. The annual leave has remained within the tolerance for most of August but needs to be robustly managed next year.



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



13.0 Turnover rates

13.1 Turnover rates across the clinical areas have remained static overall for the last four months but with wide variation in different specialities. Turnover rates for the month of August have risen to a high of 14%. All staff that leave the trust are invited to attend an exit interview with the Human Resources department.

13.2 All senior nurse midwife managers are also encouraged to discuss the reasons for leaving the trust with individual members of staff. Where deficits have been identified as the cause of the departure an attempt is made to put these right to prevent other staff leaving.

Turnover rates	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Hewitt Centre	10.00%	10.00%	10.00%	12.00%	22.00 %
Genetics	11.00%	8.00%	8.00%	5.00%	4.00%
Gynaecology	15.00%	12.00%	12.00%	13.00%	18.00%
Theatres	5.00%	36.00%	21.00%	17.00%	21.00%
Imaging Services	18.00%	18.00%	6.00%	12.00%	12.00%
Maternity Services	6.00%	7.00%	7.00%	7.00%	11.00%
Neonatology	7.00%	7.00%	7.00%	6.00%	14.00%
Pharmacy	6.00%	6.00%	6.00%	6.00%	12.00%
Trust Total	**10.00%**	**10.00%**	**10.00%**	**9.00%**	**14.00%**

14.0 Professional Registration

14.1 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 August two nurses and one midwife failed to revalidate with the Nursing & Midwifery Council and have 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	Aug-17
Hewitt Centre	0	0	0	0	0
Genetics	0	0	0	0	0
Gynaecology	0	0	0	1	2
Theatres	0	0	0	0	0
Imaging Services	0	0	0	0	0
Maternity Services	1	0	0	0	1
Neonatology	0	1	0	0	0
Pharmacy	0	0	0	0	0
Trust Total	**1**	**1**	**0**	**1**	**3**

15.0 Conclusion

15.1 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
August 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)				
18135.5	17664	4922	4519.5	16962.5	16239.5	3841	3254.5	97.4%	91.8%	95.7%	84.7%

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)
3113	10.9	2.5	13.4

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%
Aug-17	Gynae Ward	99.3%	93.1%	99.2%	94.5%

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%

Aug-17	Induction & Delivery Suites	88.9%	130.6%	86.5%	84.9%
	Maternity Base	88.7%	81.3%	88.9%	97.8%
	MLU & Jeffcoate	86.0%	93.5%	77.4%	103.2%
	Maternity Total	88.3%	95.0%	85.1%	93.1%

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%
Aug-17	Neonatal Care	114.1%	75.8%	113.5%	46.8%

Agenda Item	2017/ 283

MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	Performance Dashboard Month 5	
DATE OF MEETING:	6 October 2017	
ACTION REQUIRED	**For Assurance**	
EXECUTIVE DIRECTOR:	Jeff Johnston, Director of Operations	
AUTHOR(S):	Jeff Johnston, Director of Operations	
LINK TO STRATEGIC OBJECTIVES:	**1. To develop a well led, capable motivated and entrepreneurial workforce** **2. To be ambitious and efficient and make best use of available resources** **5. To deliver the best possible experience for patients and staff** **3. To deliver safe services**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Safe:*** *Ineffective understanding and learning following significant events* ***Efficient:*** *Inability to deliver the best clinical outcomes for patients* ***Experience:*** *Poorly delivered positive experience for those engaging with our services*	***Effective:*** *Inability to deliver the best clinical outcomes for patients* ***Well Led:*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust*
WHICH CQC KLOE FUNDAMENTAL STANDARD/S DOES THIS REPORT RELATE TO?	***Safe:*** *1.1 Safe - Reg12 Safe care and treatment* ***Caring***: ***Responsive:***	***Effective:*** ***Well Led:*** *5.2 Safe - Reg 17 Good Governance*
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT (e.g.: NHS Improvement Compliance/E&D/NHS Constitution)	**NHS Improvement compliance**	
FREEDOM OF INFORMATION STATUS (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION:	The Board note the content of the report	

(eg: The Board/Committee is asked to:-….)		
PREVIOUSLY CONSIDERED BY:	**Committee name**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Noted

1. Introduction

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

Performance Dashboard - Trust Bo

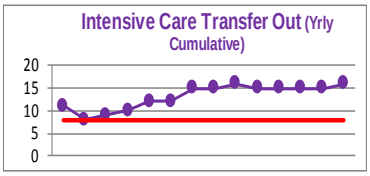
2. Performance

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 16 patients, the group consider the transfers to be appropriate.

Intensive Care Transfer Out (Yrly Cumulative)	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	Aug-17
Actual	11	8	9	10	12	12	15	15	16	15	15	15	15	16
Target	8	8	8	8	8	8	8	8	8	8	8	8	8	8



The target is based upon previous years numbers of transfers and as discussed previously at Board is an historic number for comparison purposes. This demonstrates the increased number of transfers from Crown street site for intensive care at the Royal site. The target should really be zero for this indicator as our services should be co-located with an adult intensive care unit. This is unachievable whilst services are run on the Crown street site.

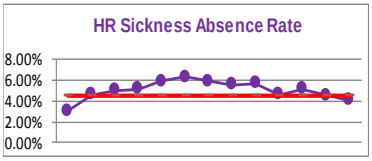
2.2 All Cancers: Targets

The Trust continues to perform well against all cancer targets though it should be recognised this is a challenging target that requires significant management input.

The service continues to work closely with the Cancer Alliance, NHSE and the Clinical Commissioning Group.

2.2 Sickness and Absence Rates

HR Sickness Absence Rate	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	Aug-17
Actual	3.09%	4.61%	5.03%	5.16%	5.88%	6.32%	5.92%	5.56%	5.71%	4.64%	5.17%	4.56%	4.05%	4.51%
Target	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%



The overall single month sickness figure increased by 0.46% from 4.05% in month four to 4.51% in month five. This is currently just 0.01% above the Trust target figure.

Although it fell slightly again in month five, the sickness rate for the largest service, Maternity, remains significantly above target at 6.48%. There are now nine services rated as green, three are rated as amber and five are rated as red (Estates & Facilities, Gynaecology, Integrated Admin, Maternity, and Neonates.).

The proportion of overall sickness split by short term & long term remained unchanged 40%/60%. In terms of diagnoses, gastrointestinal problems was the most common diagnosis, followed by anxiety/stress/depression, and other musculoskeletal problems.

Managers are continuing to work closely with their HR teams to ensure that individual cases are managed appropriately, that staff are managed on the appropriate stages and that staff are supported in returning to work as soon as is appropriate. Support for managers is also provided by Occupational Health, particularly in terms of advice for supporting staff off long term in returning to work.

The Human Resources Department provide detailed absence information and advice to support managers in addressing sickness absence. They also provide training to new and existing managers in how to effectively manage sickness absence. This now includes a series of 'lunch and learn' training sessions which are open to all managers. These are being developed as 'bite-size' learning sessions that will cover a range of different subjects, including a number of sessions on different aspects of attendance management. Managers whose departments are not meeting Trust targets are being required to submit recovery plans to demonstrate how they will achieve them. A working group which includes staff side representatives has been set up to look at sickness absence across the Trust, and the Trust's Attendance Management Policy is currently under review.

3. Emerging concerns

As reported last month Gynaecology is not achieving contracted activity targets for a number of reasons and a plan to mitigate any clinical, financial or performance risks is being formulated to be presented back to Finance Performance and Business Development in October. One of the most significant impacts is the reduced number of junior doctors available for clinics due to gaps in the medical rota, this is now having a impact on capacity. This is increasing the waiting time for follow up appointments and could impact upon the 18 week RTT (compliance now at 93.67 which is the lowest all year). The management team are managing patients along pathways to maintain 18 week targets but waiting times for follow ups are a concern. A further in depth review of individual consultant clinics and waiting times is underway with a view to redesign pathways.

4 Conclusion

The Trust is achieving all its National access and A & E targets, although risks are emerging with regard to the 18 weeks which is currently being effectively managed. ITU transfers remain a continuing clinical risk that is managed by robust clinical policies and procedures and the experience of clinicians, this particular issue remains a strong focus of our long term strategy. Sickness remains an issue but robust management intervention continues to maintain sickness close to the 4.5% target.

5 Recommendation

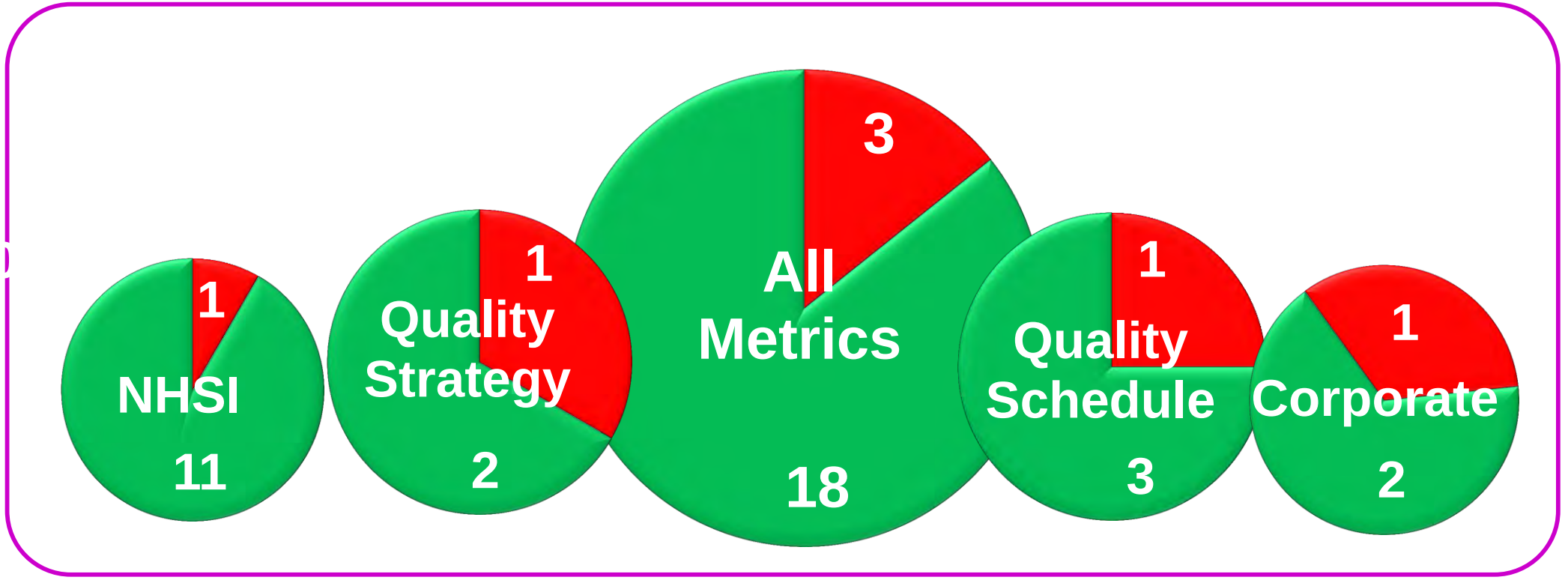
The Board note the content of the report

APPENDIX 1

Performance and Information Department
Performance Team

Liverpool Women's NHS Foundation Trust

Performance Report for Trust Board — Month 5 - August 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 5 - August 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	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	0										
Infection Control: MRSA	KPI105 (EAS4)		0	0	0	0		0	0										
Never Events	KPI181		0	1	0	0		0	0										
NHSE / NHSI Safety Alerts Outstanding	KPI193		0	0	0	0		0	0										
Infection Control: Clostridium Difficile - infection rate	KPI320		TBC	0	0	0		0	0										
Mortality Rates: Hospital Standardised Mortality Rates (HSMR) - weekend (1 Month Behind)	KPI321		TBC	0	0	0		0	1										
Mortality Rates: Hospital Standardised Mortality Rates (HSMR) - weekday (1 Month behind)	KPI321		TBC	0	0	0		0	0										
Mortality Rates: Summary Hospital Mortality Indicator	KPI322		TBC	0	0	0		0	1										

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%	4.51%										

Liverpool Women's NHS Foundation Trust

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%**	**93.67%**										
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%**	**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%**	**90.91%**											
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%**	**92.31%**										
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%**	**95.24%**											
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**	**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**	**No Pts Applicable**										
Complaints: Number Received	**KPI038**	**Kevin Robinson**	**<= 15**	**10**	**9**	**5**		**5**	**11**										

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%	4.51%							

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	0							
A&E: Total Time Spent in A&E 95th percentile	KPI012 (KPI_62)	Monthly	Sharon Owens	<= 240	235	231	220	221	221							
Friends & Family Test (Upper quartile will recommend)	KPI089	Monthly		>= 75%	97.5%	98.5%	85.2%	96.7%	94.6%							

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%	4.05%	4.51%							

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	0							
Mortality Rates: Summary Hospital Mortality Indicator	KPI322			TBA	0	0	0	0	1							

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	11							

LWH Corporate 2017/18 Month 5 - August 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%	0.42%							
Deaths (All Live Births within 28 Days) Booked births	KPI168		< 4.6%	0.15%	0.26%	0.29%	0.15%	0.43%							

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	16							

Agenda Item	17/284

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Month 5 Finance Report**
DATE OF MEETING:	Friday, 06 October 2017
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 (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:-….)***	***Note the Month 5 Financial Position and Forecast Outturn***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee Or type here if not on list: ***Click here to enter text.***
	Date of meeting	Monday, 25 September 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 5 the Trust is £0.042m favourable against the planned £2.265m deficit, and is forecasting delivery of the full year control total.

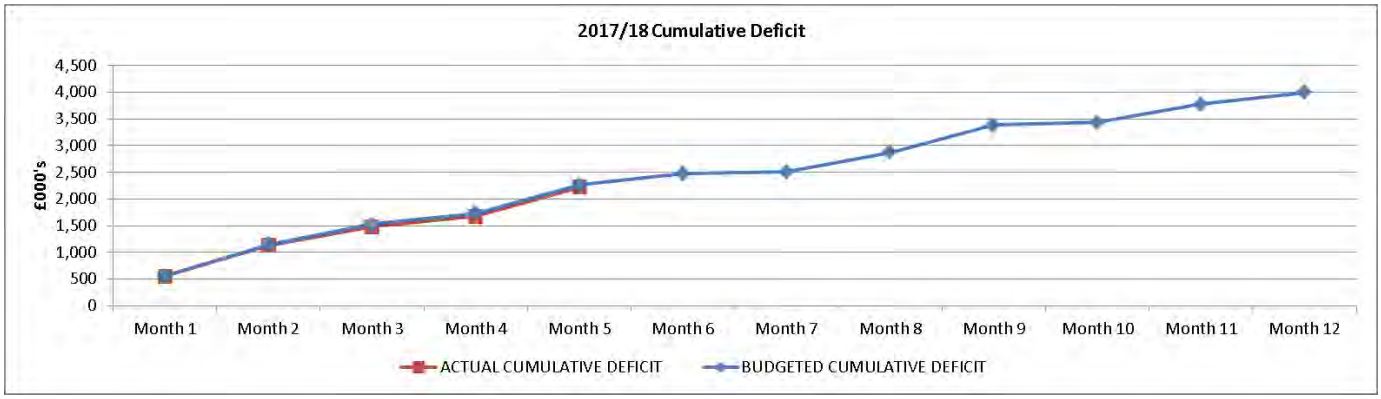
The Trust delivered a finance and use of resources' of 3 in month which is equivalent to plan.

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

Report

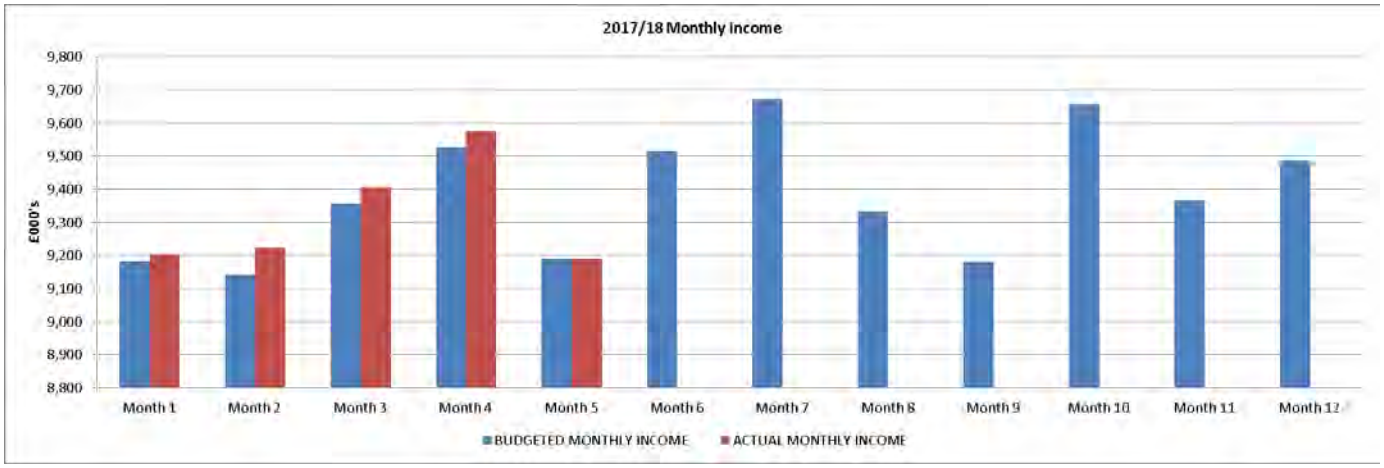
1. Month 5 2017/18 Summary Financial Position

The 2017/18 deficit is profiled below.



The Trust is achieving the planned deficit at Month 5.

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.



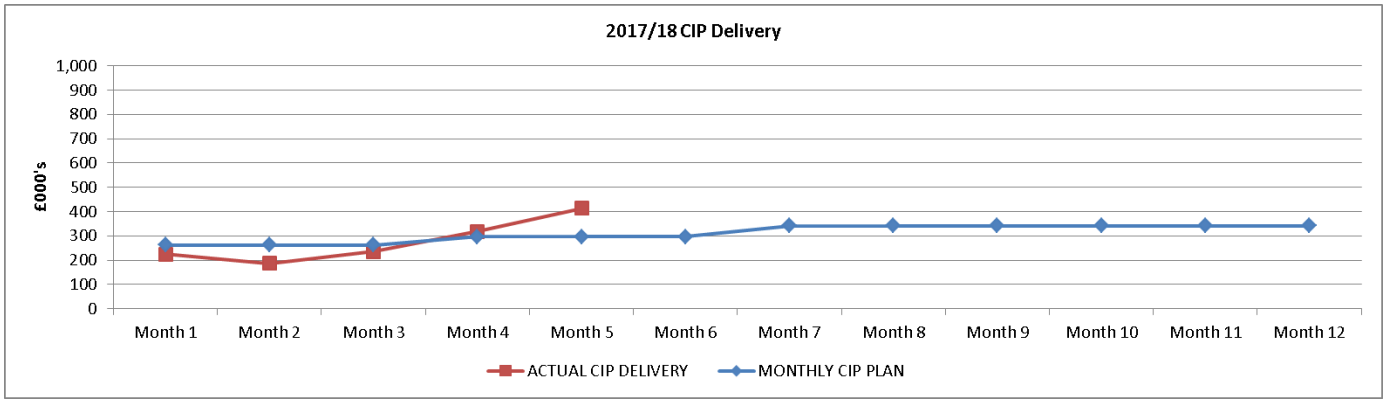
To date, the CCG block payment has been higher than what would have been received under PbR for the level of activity during 2017/18. This has arisen across both General Gynaecology and Maternity, with activity levels in each currently below plan.

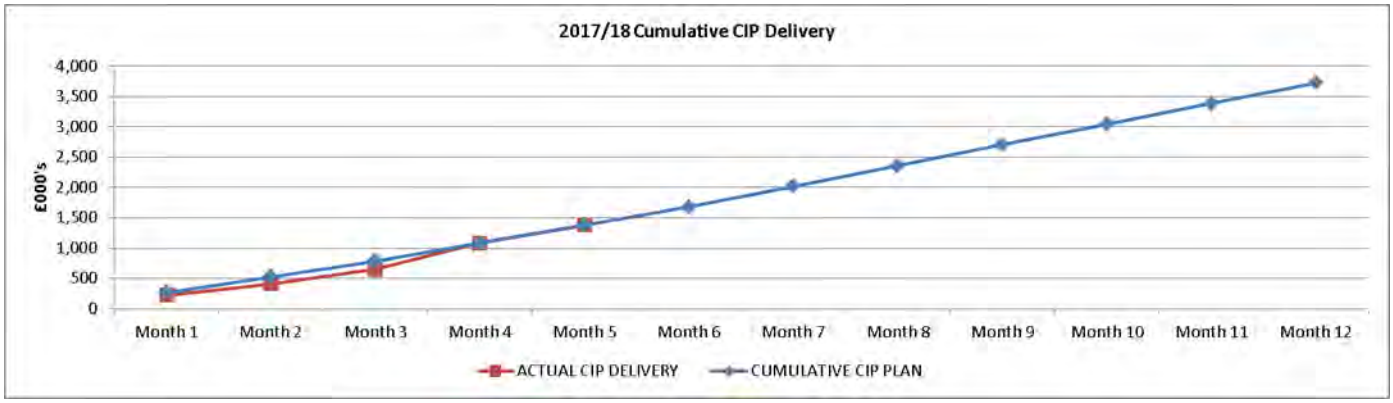
Pay expenditure is in line with plan overall, non-pay overspends have arisen year to date as a result of delays to some CIP schemes which are now being successfully mitigated across the wider Trust.

2. Month 5 CIP Delivery

CIP is profiled based on expected delivery across the financial year. The Trust is forecasting the delivery of the full £3.7m CIP target for 2017/18, with mitigations reflected in the reported position. £0.7m of this full year forecast is currently on a non-recurrent basis.

The Month 5 position reflects the recent successful negotiations to reduce the cost of the Trust's pathology contract for 2017/18.





Scheme performance and recurrent delivery in both 2017/18 and future financial years remains focus of the Trust's Turnaround and Transformation Committee.

3. Service summary overview

As previously reported, the Maternity service is forecasting an overspend on pay - arising from additional recruitment in midwifery in response to concerns raised within the service - whilst Gynaecology and Theatres are also forecasting to come in behind plan as a result of reduced income.

Activity across Maternity and General Gynaecology has been behind plan during 2017/18, with income largely being protected by the block contract arrangement. The position improved at Month 5, however a detailed review of activity remains in place to establish remedial actions moving forward.

Neonates continue to manage the service within budget, and are forecasting out-performance to continue throughout 2017/18.

Hewitt Fertility Centre was slightly ahead of plan and is forecast to deliver its current contribution target – with work ongoing to ensure delivery of a further £0.5m contribution from 2018/19.

Genetics continues to run well within budget. The service is currently working to confirm the recurrent delivery of savings for 2018/19.

4. Budget Virements

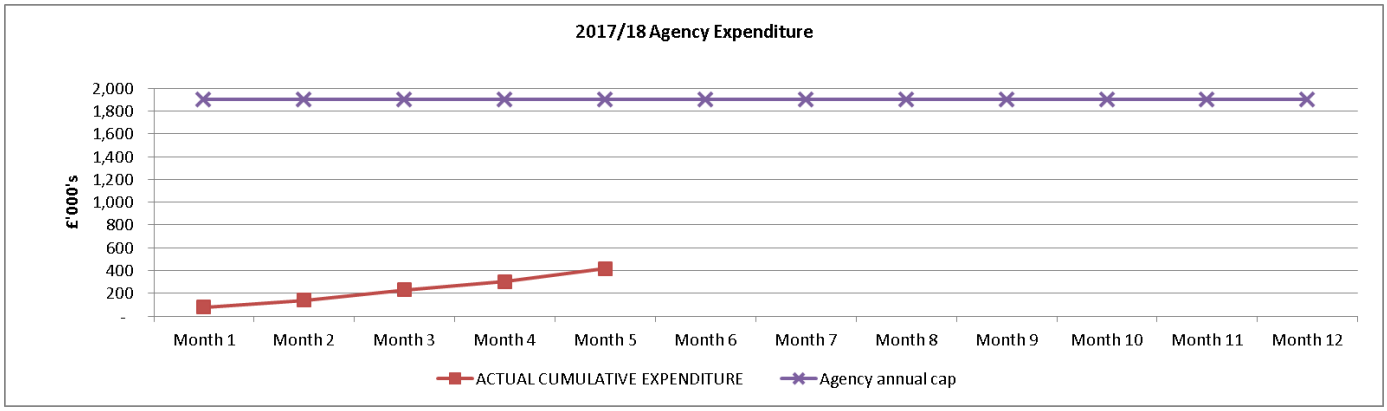
The Trust's Standing Financial Instructions require budget virements over £100,000 to be reported to the Board. The virements that are reflected in the Month 5 position are:

Division	Transacted from	Transacted to	Description	Value
Gynaecology	Gynaecology non-pay	Gynaecology pay	Gynaecology and theatres efficiencies formally transacted on individual subjective codes following detailed identification across specific pay lines	£550,000
Genetics	Genetics	PMO	Additional CIP identified in year, transacted from genetics budget	£204,000

These virements were noted at Finance, Performance and Business Development Committee in September 2017.

5. Agency Spend

The annual agency cap set by NHSI for the Trust is £1.9m. In Month 5 the Trust incurred £0.114m of agency expenditure (cumulative £0.417m) and plans to remain within the cap for the financial year.



6. Cash and borrowings

The Trust has an operational cash borrowing requirement of £4.0m for 2017/18. The Trust continues to submit 13 week cash flow statements each month to DH, there was no requirement for a cash drawdown in Month 5.

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.

7. BAF Risk

There are no changes proposed in relation to the BAF.

8. Conclusion & Recommendation

The Board are asked to note the Month 5 financial position and the enacting of the budget virements in relation to CIP.

Appendix 1 – Board pack

Appendix 1

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M5

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	369	326	2,341	2,189
(b) PDC + Interest Payable + Loans Repaid	800	1,232	2,532	4,748
CSC Ratio = (a) / (b)	**0.46**	**0.26**	**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	(3,392)	(4,001)	(2,598)	(3,212)
(b) Expenditure	46,035	46,277	110,277	110,783
(c) Daily Expenditure	307	309	306	308
Liquidity Ratio = (a) / (c)	**(11.1)**	**(13.0)**	**(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)	2,265	2,222	3,998	3,995
Total Income	(46,400)	(46,597)	(112,608)	(112,957)
I&E Margin	**-4.88%**	**-4.77%**	**-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)		-4.77%		-3.54%
I&E Margin (Plan)		-4.88%		-3.55%
I&E Variance Margin	**0.00%**	**0.11%**	**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	802	802	1,924	1,924
YTD Agency Expenditure	540	417	1,301	902
	-32.64%	**-47.98%**	**-32.38%**	**-53.12%**
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: M5
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	(8,487)	(8,478)	(10)	(43,202)	(43,279)	77	(102,883)	(103,156)	273
Non-Clinical Income	(704)	(712)	9	(3,198)	(3,318)	120	(9,725)	(9,800)	76
Total Income	**(9,191)**	**(9,190)**	**(1)**	**(46,400)**	**(46,597)**	**197**	**(112,608)**	**(112,957)**	**348**
Expenditure									
Pay Costs	5,666	5,660	6	28,360	28,281	79	67,853	67,690	163
Non-Pay Costs	2,225	2,262	(37)	11,121	11,443	(322)	26,696	27,365	(669)
CNST	1,311	1,311	0	6,553	6,553	0	15,728	15,728	0
Total Expenditure	**9,201**	**9,233**	**(31)**	**46,035**	**46,277**	**(243)**	**110,277**	**110,783**	**(506)**
EBITDA	**10**	**43**	**(32)**	**(365)**	**(320)**	**(45)**	**(2,331)**	**(2,174)**	**(158)**
Technical Items									
Depreciation	366	352	15	1,834	1,806	29	4,419	4,414	5
Interest Payable	36	23	13	180	117	63	432	266	166
Interest Receivable	(1)	(1)	1	(4)	(6)	2	(10)	(15)	5
PDC Dividend	124	128	(4)	620	628	(8)	1,488	1,508	(20)
Profit / Loss on Disposal	0	(1)	1	0	(1)	1	0	(1)	1
Total Technical Items	**525**	**500**	**25**	**2,630**	**2,543**	**87**	**6,329**	**6,172**	**158**
(Surplus) / Deficit	**536**	**543**	**(7)**	**2,265**	**2,223**	**42**	**3,998**	**3,998**	**(0)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
EXPENDITURE: M5
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	339	367	(28)	1,701	1,769	(68)	4,085	4,164	(80)
Medical	1,247	1,251	(4)	6,237	6,205	32	15,078	14,934	143
Nursing & Midwifery	2,521	2,513	8	12,634	12,600	34	30,109	30,249	(140)
Healthcare Assistants	412	411	0	2,077	2,055	22	4,924	4,893	31
Other Clinical	545	497	48	2,731	2,627	104	6,554	6,482	72
Admin Support	140	161	(22)	701	790	(89)	1,679	1,882	(203)
Corporate Services	342	345	(2)	1,730	1,817	(87)	4,125	4,183	(57)
Agency & Locum	120	114	5	548	417	131	1,299	902	398
Total Pay Costs	**5,666**	**5,660**	**6**	**28,360**	**28,281**	**79**	**67,853**	**67,690**	**163**
Non Pay Costs									
Clinical Suppplies	720	705	15	3,556	3,549	7	8,521	8,528	(6)
Non-Clinical Supplies	561	558	3	2,774	3,023	(249)	6,768	7,119	(351)
CNST	1,311	1,311	0	6,553	6,553	0	15,728	15,728	0
Premises & IT Costs	415	450	(35)	2,083	2,252	(169)	4,978	5,198	(220)
Service Contracts	529	549	(20)	2,708	2,619	89	6,429	6,520	(91)
Total Non-Pay Costs	**3,536**	**3,573**	**(37)**	**17,675**	**17,997**	**(322)**	**42,424**	**43,093**	**(669)**
Total Expenditure	**9,201**	**9,233**	**(31)**	**46,035**	**46,277**	**(243)**	**110,277**	**110,783**	**(506)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M5
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	(3,712)	(3,650)	(62)	(18,823)	(18,731)	(92)	(45,612)	(45,518)	(94)
Expenditure	1,698	1,770	(72)	8,510	8,560	(51)	20,398	20,659	(261)
Total Maternity	**(2,013)**	**(1,880)**	**(134)**	**(10,313)**	**(10,170)**	**(143)**	**(25,214)**	**(24,859)**	**(355)**
Gynaecology									
Income	(2,025)	(1,941)	(84)	(10,741)	(10,568)	(173)	(25,742)	(25,498)	(244)
Expenditure	859	833	26	4,305	4,289	15	10,317	10,354	(37)
Total Gynaecology	**(1,166)**	**(1,107)**	**(58)**	**(6,437)**	**(6,279)**	**(158)**	**(15,425)**	**(15,144)**	**(281)**
Theatres									
Income	(42)	(39)	(2)	(208)	(201)	(6)	(499)	(494)	(5)
Expenditure	642	644	(2)	3,208	3,198	10	7,700	7,632	69
Total Theatres	**600**	**605**	**(5)**	**3,001**	**2,997**	**4**	**7,201**	**7,138**	**64**
Neonatal									
Income	(1,356)	(1,374)	18	(6,779)	(7,018)	239	(16,249)	(16,718)	469
Expenditure	945	944	1	4,725	4,737	(12)	11,341	11,651	(310)
Total Neonatal	**(411)**	**(430)**	**19**	**(2,054)**	**(2,281)**	**228**	**(4,908)**	**(5,067)**	**159**
Hewitt Centre									
Income	(809)	(840)	32	(4,079)	(4,279)	200	(9,971)	(10,168)	197
Expenditure	623	629	(6)	3,113	3,160	(47)	7,471	7,666	(195)
Total Hewitt Centre	**(186)**	**(212)**	**26**	**(966)**	**(1,119)**	**153**	**(2,501)**	**(2,502)**	**2**
Genetics									
Income	(600)	(603)	3	(3,002)	(2,950)	(52)	(7,204)	(7,071)	(133)
Expenditure	461	459	2	2,306	2,099	207	5,535	5,233	302
Total Genetics	**(140)**	**(144)**	**4**	**(696)**	**(851)**	**155**	**(1,669)**	**(1,838)**	**168**
Clinical Support									
Income	(23)	(28)	5	(127)	(158)	31	(295)	(351)	55
Expenditure	757	713	44	3,841	3,835	6	9,143	9,207	(64)
Total Clinical Support & CNST	**734**	**685**	**49**	**3,714**	**3,677**	**37**	**8,848**	**8,856**	**(8)**
Corporate & Trust Technical Items									
Income	(625)	(715)	90	(2,642)	(2,693)	52	(7,037)	(7,140)	103
Expenditure	3,743	3,741	2	18,658	18,942	(285)	44,702	44,554	148
Total Corporate	**3,117**	**3,025**	**92**	**16,016**	**16,249**	**(234)**	**37,666**	**37,414**	**251**
(Surplus) / Deficit	**536**	**543**	**(7)**	**2,265**	**2,223**	**42**	**3,998**	**3,998**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M5
YEAR ENDING 31 MARCH 2018

BALANCE SHEET £'000	YEAR TO DATE Opening	M5 Actual	Movement
Non Current Assets	**72,688**	**73,452**	764
Current Assets			
Cash	4,897	8,583	3,686
Debtors	8,201	8,004	(197)
Inventories	366	421	55
Total Current Assets	**13,464**	**17,008**	**3,544**
Liabilities			
Creditors due < 1 year	(10,577)	(17,731)	(7,153)
Creditors due > 1 year	(1,717)	(1,706)	11
Loans	(17,175)	(16,688)	487
Provisions	(3,011)	(2,887)	124
Total Liabilities	**(32,480)**	**(39,012)**	(6,531)
TOTAL ASSETS EMPLOYED	**53,672**	**51,448**	**(2,223)**
Taxpayers Equity			
PDC	37,420	37,420	0
Revaluation Reserve	12,233	12,233	0
Retained Earnings	4,019	1,795	(2,223)
TOTAL TAXPAYERS EQUITY	**53,672**	**51,448**	**(2,223)**

Agenda Item	17/285

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Fit for Future Generations** **Northern England Clinical Senate Report - Review of Services Provided by Liverpool Women's NHS Foundation Trust**
DATE OF MEETING:	Friday, 06 October 2017
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	Click here to enter text.
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 note the assurance provided by the independent review, by Northern England Clinical Senate, of the services provided by the 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.***

NHS
Northern England
Clinical Senate

Liverpool Clinical Commissioning Group

Healthy Liverpool Programme

Review of Services Provided by Liverpool Women's NHS Foundation Trust

A review by Northern England Clinical Senate

May/June 2017

1. Introduction

1.1 Liverpool Clinical Commissioning Group (LCCG) has produced a Pre-Consultation Business Case (PCBC) following a review of services provided by Liverpool Women's NHS Foundation Trust. The PCBC sets out the options appraisal process and the resultant short list of reconfiguration options for public consultation. As part of the preparation for public consultation it was decided to request an independent review by the Northern England Clinical Senate of relevant aspects of the PCBC. The review is focused primarily on assessing whether the ongoing provision of:

- Consultant and midwife led obstetric services
- Gynaecology services including gynaecological oncology services
- Neonatal services

are best undertaken at the current Liverpool Women's Hospital (LWH) site or whether another site or multiple sites in Liverpool might be better placed to provide these services in the future.

1.2 The Terms of Reference agreed for the review include the following objectives:-

Aims and Objectives of the Clinical Review:

To ascertain, using the clinical evidence base and clinical standards described in the PCBC work to date, whether the clinical case for change, option appraisal development and proposals for consultation offer the best clinical options for sustainable, high quality and optimal patient experience for future Liverpool Women's services.

Main Objectives of the Clinical Review:

- Assess the validity of the case for change and the service change proposals.
- Comment on the clinical appropriateness & sustainability (or not) of all four options in the PCBC.
- Consider whether the preferred option supports the strategic intent and policy direction of women's services nationally and women and children's services locally (Cheshire and Merseyside footprint as LWH serves a wider population than Liverpool).
- Comment on the sustainability and clinical risk of the 'workarounds' currently in place and referenced in the PCBC.

A copy of the full Terms of Reference is included as **Appendix 1.**

1.3 Clinical Senate Review Team Members

Chair: Prof Andrew Cant, Chair Northern Clinical Senate, Consultant in Paediatric Immunology & Infectious Diseases, Newcastle upon Tyne Hospital NHS FT.

Derek Cruickshank, In Hospital Clinical Lead for the Better Health Programme and the Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby Sustainability and Transformation Plan & Secondary Care Doctor, Sunderland CCG (Formerly Consultant Gynaecology/Oncologist, James Cook University Hospital).

Sundeep Harigopal, Consultant Neonatal Paediatrician, Newcastle upon Tyne Hospital NHS FT.

Lesley Heelbeck, Head of Midwifery, Gateshead Hospital NHSFT.

Robin Mitchell, Clinical Director NECN, formerly Consultant in Anaesthetics and Intensive Care Medicine.

Helen Simpson, Consultant Obstetrician, South Tees NHS FT.

Sharon English, Lead Clinician for Neonatal Services, Leeds Children's Hospital.

Gareth Hosie, Consultant Paediatric Surgeon, Newcastle Upon Tyne Hospitals NHS FT.

Managerial and business support to the panel was provided by Roy McLachlan, Associate Director for Clinical Networks and Senate, Northern England, and Karen Pellegrino, PA to the Northern England Clinical Senate.

2. Background

2.1 LWH is a purpose built hospital which opened in 1995, located in Crown Street, Liverpool. It provides a range of local services for women and babies and regional tertiary specialist services for the residents of Liverpool and its surrounding areas of Cheshire and Merseyside.

2.2 LWH is one of only two stand-alone specialist Trusts in the country providing care exclusively to women and babies. In 2015/16 LWH delivered over 8600 babies, provided gynaecological care to over 5800 patients and delivered intensive care to over 1000 babies (**see appendix 4**).

2.3 In 2016, LCCG established formal governance arrangements to undertake a full option appraisal process regarding the future location of services provided on the Crown Street site. The reason for doing this was to ensure the long term viability of services provided out of LWH. A long list of options was established and through a decision making process including developing criteria, scoring options against these criteria and gradually reducing the number of options based on the scoring. A short list of four options, with a preferred option identified, has been agreed for formal public consultation. The four options are:-

- Develop and enhance the Crown Street site with an adult Intensive Care Unit, blood bank, CT/MRI/IR and neonatal refurbishment (known as option C1).
- Minimal enhancement to the Crown Street site to minimise emergency transfers (blood bank, leased CT) and neonatal refurbishment (known as option C2).
- Relocation of services to a new build on the Alder Hey site, with access to diagnostics and Adult ICU (known as option D1).
- Relocation of services to a new build on the Royal Liverpool Hospital (RLH) site with access to the full range of adult services, including diagnostics, ICU and specialists (known as option D3-N).

2.4 The Cheshire and Mersey Critical Care Network (CMCCN) has issued a statement indicating there would not be support for establishing a new adult critical care unit at Alder Hey Hospital (**Appendix 2**).

The North West Neonatal Operational Delivery Network (NWNODN) has also issued a statement advocating the co-location of maternity, neonatal intensive care and paediatric subspecialty (including neonatal surgery) as being the only configuration of services that is fully compliant with all national standards (**Appendix 3**). However their review also puts forward several suggestions for mitigating risks should neonatal intensive care be co-located on an adult hospital site.

2.5 The juxtaposition of these two sets of standards is at the core of the challenge facing LCCG in coming to a decision regarding the future location of services.

3. Methodology

3.1 Early in the process for managing the Clinical Senate review it was suggested that representatives from LCCG meet with members of the review panel in the North East to spend time briefing them about the background to the PCBC, the option appraisal process that was followed, and some of the detail behind the long and short lists generated.

This meeting took place on 25th May, 2017 in Durham. A copy of the presentation given to the members of the review panel is given as Appendix 4.

3.2 In advance of this meeting the members of the review panel were sent six documents:-

- Copy of the latest version of the PCBC (dated January 2017).
- Copy of section 11 of Healthy Liverpool – the Blueprint; this is the section regarding the Hospitals Programme.
- Copy of the latest statements from CMCCN and NWNODN which were tabled at a meeting of the Programme Board on 12th May, 2017.
- Copy of a letter from the Chair of the Medical Staff Committee at LWH to the Chief Executive and Medical Director of the Foundation Trust dated 13th February, 2017 outlining support for the PCBC.
- Copy of a letter from the Chief Executive of Alder Hey NHS Foundation Trust to the Chief Officer of LCCG dated 10th March, 2017 outlining detailed feedback on the options appraisal contained in the PCBC.

Towards the end of the meeting on 25th May it was agreed that the only additional document for the panel to consider in advance of the review was the Operational Plan for LWH 2017-19.

3.3 The review panel met representatives of LCCG, NHS England's Assistant Regional Director of Specialised Commissioning, the Medical Director and a Clinical Director from LWH in Liverpool on the evening of 7th June for a further briefing and update prior to a series of meetings with clinical representatives of LWH and AH on 8th June. The programme for these meetings and attendees are included as **Appendices 5 and 6** respectively. A brief tour of limited parts of the LWH site was possible on the morning of 8th June but time constraints meant that it was not possible to visit other sites in the city; the panel particularly noted a request to visit Alder Hey but this was not possible in the time available.

3.4 A draft of this report was sent to LCCG to check for accuracy on 30th June 2017.

4. Issues/Views expressed during review

In this section it is only intended to highlight significant issues/views expressed during the review. It is not intended to give an extensive record of the wide ranging and very helpful discussion which took place in each of the planned sessions.

4.1 Key Issues/Views – Commissioners

4.1.1 The interdependences between Obstetrics and Gynaecology mean that splitting these services would lead to significant clinical risk.

4.1.2 There are currently eight regional providers of Neonatal care at varying levels. Commissioners clearly see Liverpool as a fixed future point for Level 3 Neonatal services.

4.1.3 It was noted that the Neonatal surgery service at Alder Hey currently does not meet National Specifications for Neonatal Intensive Care The panel understood that following a clinically led options appraisal, the C&M Neonatal ODN and NHS England Specialised Commissioning have endorsed the option to create a Single Neonatal Service, staffed by a single workforce, operating across the two sites (AH and LWH) and that work is now underway to implement this service change. The panel recognised that this would bring continuing challenges of sustainability of staffing.

4.1.4 Neonatal services at LWH do not meet national service specifications because necessary support services and co-located services are not provided on the LWH site.

4.1.5 Also recognised that the direction of travel should be towards having co-location of Gynaecology, Urology and Colorectal services under the umbrella of 'Pelvic Surgery'.

4.1.6 It was noted that a review of Maternity services across the wider area is under way.

4.1.7 There is also a prevailing view that it would not be possible to provide critical care for Obstetric patients at Alder Hey with a clear statement to this effect coming from the Adult Critical Care ODN (**see Appendix 3**)

4.2 Key Issues/Views – LWH

4.2.1 Obs/Midwifery

4.2.1.1 Trust colleagues felt that their service has a very good reputation, but that the challenges faced would make this very difficult to maintain. A key dilemma faced by commissioners was balancing the needs of increasing numbers of complex obstetric cases and the needs of complex neonates, given the current configuration of services across two sites. It was acknowledged that a compromise, 'least bad' rather than an 'ideal' solution was likely.

4.2.1.2 Noted that current obstetric consultant cover of 112 hours a week needs to be extended by recruiting more consultants when investment allows, to fulfil national standard.

4.2.1.3 Threshold for transferring women to the Royal Liverpool is high because of the distance to a level 3 Intensive Care Unit (ICU) and the important need to transfer with all the risks involved. This means that women stay on an High Dependency Unit (HDU) facility at LWH longer than may be clinically optimal to try to avoid the need to transfer. If a mother is transferred to RLH, the baby cannot be transferred at the same time as well.

4.2.1.4 The lack of a blood bank on the site means that 6 units of O negative blood are stored for emergency haemorrhage. It was noted that the group specific blood can be obtained within an hour with cross matching taking an additional 20 minutes. The trust has been at the forefront in adopting cell salvage techniques, which, while commendable, is not a replacement for an on-site blood transfusion lab.

4.2.1.5 Any intra-operative bowel damage requires input from Gynae Oncology or the Colorectal team from the Royal Liverpool Hospital.

4.2.1.6 Key diagnostic services such as cross sectional imaging falls far short of the standard expected in a unit of this size (8600 births p.a.). There is currently no CT or MRI facility on site at LWH and no resident Radiographer out of hours. Waits for a Radiographer out of hours were reported as being typically an hour. Imaging is, therefore, limited to plain films only. Reporting is limited to 3 PAs per week with no prospective cover. Only Alder Hey has a full range of imaging available for neonates.

4.2.2 Neonatal Services

4.2.2.1 Noted that the unit acts as a Neonatal Intensive Care Unit (NICU) for the wider area of Cheshire and Merseyside as well as for the City of Liverpool. The range of care includes neonatal intensive care, pre-operative, post-operative care, (surgery at Alder Hey with the baby returning to LWH for post-operative care in case of pre-term) management of antenatally diagnosed congenital malformations, and congenital cardiac care until transfer to Alder Hey.

4.2.2.2 Currently there is 0.5 WTE Consultant Neonatal input at Alder Hey with the joint appointment of a surgeon pending. No specialist surgeon or paediatric surgeons on site at LWH.

4.2.2.3 As set out in 4.2.1.6 above, diagnostic services and facilities fall short of the standard expected.

4.2.2.4 There are no dedicated support services available at LWH (physiotherapy, Occupational Therapy, Psychology, Dietetics and Speech and Language Therapy). Such support services are available at Alder Hey. This does not meet current service specifications.

4.2.2.5 Current estate facilities for Neonatal services at LWH are too small and the consequent crowding leading to considerable challenges for infection control with, for example, MRSA rates quite high. Average occupancy rate is also high at 84% (21,000 in-patient days).

4.2.2.6 Access to other medical specialties is on a good will basis with no service level agreements in place.

4.2.3 Gynaecology

4.2.3.1 Services noted as being the only stand-alone Gynaecology service in the UK including a dedicated Gynaecology emergency department. The service is an accredited specialist referral Centre for endometriosis and Gynaecological Cancer Centre.

4.2.3.2 There is no CT or MRI on site and no blood bank.

4.2.3.3 An Royal College of Obstetricians and Gynaecologists (RCOG) report in 2015 recommended there should be weekly joint operating lists at RLH; this has not been achieved.

4.2.3.4 Gynaecology services are needed to support complex Obstetrics particularly in the case of major haemorrhage.

4.2.3.5 The strategic direction is for all specialist cancer services in the City to be centralised on the Central University Hospital Teaching Campus. Gynaecological cancer services should be alongside all other cancer services.

4.2.3.6 If Maternity services were at Alder Hey, Gynaecology would be unable to support Obstetrics to the same standard as currently.

4.2.4 Anaesthetics/Theatres

4.2.4.1 Services feel very isolated with little or no backup therefore, operating effectively as a stand-alone tertiary service.

4.2.4.2 Recruitment to a service isolated in this way is very challenging. The example cited is an attempt to recruit into 2 consultant posts where none of the local trainees who had worked at LWH applied for the posts citing dangerous isolation as the reason. With a significant proportion of the current consultant team approaching retirement this presents a serious challenge over the next few years if vacancies to recruit following pending retirements are to be filled.

4.2.4.3 All laboratory services are provided through RLH with no on site facilities.

4.2.4.4 The possibility of a single service, City wide Anaesthetic service has been mooted. Views expressed that there was a missed opportunity to fully develop a single campus for all major hospital services which would offer the only safe, sustainable solution.

4.3 Views/ Key Issues expressed during review – Alder Hey

4.3.1 Neonatal

4.3.1.1 Acknowledged that currently the service at Alder Hey does not, and is unlikely to ever meet, national standards. There are a number of derogations in place. Long term, the future of services at Alder Hey is secure by virtue of investment in a state of the art new building in the last two years providing a fixed point for children, community, general and specialist services in the city. A full range of diagnostic and support services for Neonatal patients is also available.

4.3.1.2 Alder Hey Children's Hospital NHS FT's preferred option would be for Maternity and Neonatal services to be co-located at Alder Hey with consideration being given to options of Gynaecology moving to other potential sites in the City. Noted that it would not be feasible to carry out Neonatal surgery at LWH either currently or if located at RLH because of the risks associated with the specialised nature of the equipment and the skills of the trained personnel involved.

4.3.1.3 The Trust felt that an emphasis on delivering family central care and a seamless women's and children's service would be in line with national and local policy of direction of travel: the Trust's view is that the preferred option does not support this.

4.3.1.4 The Trust would also like to see a strategy developed for the first 1000 days of life across the City. (The panel understands a Maternity/First 1000 days workgroup exists within the Healthy Liverpool programme).

4.3.1.5 The considerable risks of transferring large numbers of Neonatal patients between hospital sites was highlighted.

4.3.1.6 The possibility of developing a supported birth unit at Alder Hey for low to medium risk mothers expecting high risk births to be explored along with upgrading/extending family support facilities.

4.3.1.7 Not confident that staffing in Neonatal service at Alder Hey is sustainable in the long term.

4.3.2 Process

4.3.2.1 The panel's attention was drawn to concerns that the Alder Hey Trust has with aspects of the process followed in leading to a preferred option and the production for a Pre Consultation Business Case (PCBC). 3 specific aspects were identified.

- Terms of reference that were not considered to be wide ranging enough to include all Women's and Children's services and also primarily focused on the financial sustainability of LWH.
- The options appraisal process undertaken over a period of a few months in mid-2016.
- A perceived unbalanced weight of input for children's and Neonatal services to the options appraisal process and the level of service user input to deciding on the weightings of the discussions and critical success factors decided upon in the option appraisal process.

4.3.2.2 After discussion and questioning it was agreed that the option appraisal process itself was not in question given the comprehensive and inclusive nature in working down from an extended long list of 20 options, a final long list of 8 options to the short list of 4 options.

4.3.2.3 The panel acknowledged that within the Executive Summary of the PCBC, section 2.1 'case for change' appears to focus on the health and clinical reasons before clearly indicating in the final paragraph that the financial sustainability is also a factor.

4.3.2.4 Within the PCBC (Appendix 1 – paragraph A1.3) the membership of the Clinical Reference Group (CRG) included five clinical representatives from Alder Hey and the Clinical Director for Neonates from LWH. Further, also in Appendix 1 of the PCBC (paragraphs A1-5, A1-7 and A1-8) two clinicians from Alder Hey were invited to the 22 April workshop (but did not attend), nine representatives from Alder Hey attended the 20 May workshop and six from Alder Hey attended 24 June workshop. The panels understanding from paragraph A2.2 of the PCBC is that the development of the options appraisal framework including Critical Success Factors and weightings was undertaken in this period and would consider the scale of representation outlined above to be reasonable.

4.3.2.5 Any comment on the breadth of services included in the original review would be outside the remit of the panel.

5. Discussion

The sub sections below contain analysis and discussion relating to the 4 objectives mentioned in the terms of reference **(Appendix 1)**.

5.1 Validity of the Case for Change and the proposals

Validity of the case for change and the proposals the clinical case for change is set out in section 6.3 of the PCBC. Overall the panel felt that there was a strong clinical case for change and would point to the following by way of support:

- The current isolated position of both Women's and Neonatal services at LWH means both services have very significant clinical risks. The balance of clinical opinion favours a move to RLH central campus with a dedicated new build and increased investment in NICU provision to support Paediatric Surgery at Alder Hey.
- Recruitment into Anaesthetic Consultant posts is a highly critical risk which would be mitigated if Obstetrics and Gynaecology services were co-located with a major acute adult hospital site with full intensive care facilities. Providing anaesthetic services from a much expanded pool of consultants (and trainees) would do much to address the resilience of the service. In addition, on-site availability of dedicated Critical Care expertise would greatly improve the quality of care available to the most seriously ill patients of LWH. There is also a need for co-location of Gynaecological Cancer Surgery with the full spectrum of 'Specialist Cancer Surgical Services' to meet Cancer standards and achieve optimal Cancer outcomes in a sustainable way.
- Change is needed to ensure safety, quality and clinical sustainability. Particular aspects that need to be addressed include provision of CT/MRI facilities, blood bank and Level 3 critical care services, all of which would be expected in a hospital such as LWH.
- Moving alongside the RLH would ensure these critical services are available for women.
- The increasing complexity of care needed for women means there is an increasing need for higher levels of critical care.
- Moving to a central site would mean Gynaecology patients who develop complications would be seen as part of the routine hospital at night process.

It should be noted, however, that the preferred option would be a compromise for Neonatal Services with the proposed configuration of Neonatal Services still not meeting national service specifications. The difficulty of developing a solution which co-locates neonatal surgery with a Neonatal Intensive Care Unit is fully acknowledged. The current specification would not be addressed with the preferred option and there remains a considerable development risk to developing a single neonatal service, including surgery, across two sites.

5.2 Clinical appropriateness of all four options in the PCBC.

C1 Develop and enhance Crown Street site	**C2 Minimal enhancement of Crown Street site**
• Neonatal estate needs upgrading. • Does not improve risks of isolation from paediatrics. • Does not reduce transfers of neonates and women. • Would need to develop adult ICU service, but staffing would be a challenge – almost certainly not feasible • Would require a significant refurbishment in support. • Does not solve anaesthetic services. • Does not address Neonatal standards. • Improvement in estate. • Does not address issue for co-location of specialised surgical Cancer services (e.g. Urology, Colorectal, Vascular and Plastics) with Gynae Oncology.	• No real risk reduction for women or neonates. • No transfusion service. • Neither service meets service specification. • Does not reduce transfers of neonates. • Does not reduce transfers of women. • Does not solve anaesthetic services • Does not address issue for co-location of specialised surgical Cancer services (e.g. Urology, Colorectal, Vascular and Plastics) with Gynae Oncology. • Improvement in estate.
D1 Relocate to Alder Hey	**D3-N Relocate to RLH site**
• Risks for women would not be reduced. • Would require adult ICU service to be set up at Alder Hey – staffing this would be challenging to the point where it is not feasible and not supported by the Critical Care Network. • Does not solve anaesthetic services issues especially recruitment. • Will not improve multi-disciplinary support for adults. • Neonatal service would be improved significantly by having single site medical, surgical and paediatric care would meet service specification. • Transfers and risks would be minimised for neonates. • Would improve staffing levels for neonatal services.	• The Neonatal Network advocates co-location. Whereas a single neonatal intensive care service operating over two sites is not the optimal configuration, the Neonatal Network considers that this can be an acceptable solution and has provided suggestions to mitigate the risks for sick neonates on an adult site. However, considerable investment is required to support this service and the longer term strategy should be to move to a single site. Such a move is likely to help with longer term sustainability of staffing. • Serious concerns about staffing and sustainability of 2 NICUs at RLUH and Alder Hey – both Alder Hey and neonatal team at LWH expressed concerns about staffing. • Addresses anaesthetic services shortfalls, including recruitment. • Maternity and Gynae service would be significantly improved. • Risks for women would be reduced significantly.

5.3 Alignment with strategic intent and policy direction nationally and taking into account potential changes in and around Liverpool.

C1 Develop and enhance Crown Street site • Does nothing to address co-location of services or centralisation of NICUs. • No future proofing around reconfiguration of regional services due to limited estate. • Does not fit with national direction • Does not fit with level minimum. • Need to develop support services.	**C2 Minimal enhancement of Crown Street site** • Does nothing to address co-location of services or centralisation of NICUs. • Does not fit with national direction. • Does not fit with level minimum.
D1 Relocate to Alder Hey • Meets service specification for neonates, not for Obstetrics or Gynaecology. • Would fit with Neonatal model of care regarding potential reduction in number of units. • Not supported by CCN,	**D3-N Relocate to RLH site** • Against national directive that neonates should be co-located with surgery and other paediatric specialities. • Meets service specification for complex Obstetrics and Gynaecology. • Helps with service requirements for Anaesthetics. • Supports local strategy for complex pelvic surgery. • Aligns with the views of the Cheshire and Merseyside Adult Critical Care network (reference Appendix 3, paragraph 4). • Helps with national direction to centralise services. • Helps with local vision to centralise where appropriate. • Does not take into account Neonatal ODN direction of travel.

5.4 Sustainability and clinical risk of current 'workarounds'.

Workaround/clinical risk	**Sustainability**	**Clinical risk**
Colocation with adult L3 CCU – reliance on transfers.	• Reliant on Ambulance availability. • Staffing an issue as staff taken from LWH.	• Risk of deterioration/death prior to/during a transfer.
No access to blood bank or critical pathology services- transfer patients, request emergency transfusions.	• Not sustainable given increased complexity of patient comorbidities. • Potential delays with inappropriate transfers.	• Significant risk (including death) for mothers and babies. • Cell salvage techniques well developed – but cannot mitigate risk entirely.
Dependence on colorectal, vascular, urology cardiology and complex diagnostics.	• Not sustainable with increase complexity of patients comorbidities and increased specialisation.	• High clinical risk for Gynae Oncology patients.
Reliance on patient transfers to meet clinical standards – AHCH and RLBUHT, including neonatal surgery.	• Wasteful and poor quality of experience for patients.	• National data supports poorer outcomes in neonates that undergo transfer.
Current neonatal facility is under size, proximity of cots may contribute to MRSA levels.	• Perhaps insufficient space for future proofing. • Floor space and layout may need redeveloping. • Increase in capacity and estate would make it sustainable.	• Footprint of neonatal unit could allow reconfiguration of clinical areas. • Risk is moderate with apparently high infection rates. • Transfer risks remain even if estate is developed.

6. Conclusions

6.1 The panel fully recognised the dilemma faced by commissioners in trying to reconcile safe and sustainable services over multiple sites in Liverpool. The only long term solution which would fully address safety and sustainability would be to move all adult and paediatric services to the new build RLH single central site. Given the considerable investment at Alder Hey and the new build Royal Liverpool Hospital, this solution is likely to be considered very difficult in the short to medium term, but would be in line with the centralising approach being considered and implemented in other parts of the UK.

6.2 The review panel considered on balance that the preferred option is aligned with the strategic intent and policy direction for women's services nationally and does sufficiently take into account potential changes being planned in women's and children's services in and around Liverpool;

6.2.1 Care for women and neonatal patients is getting more complex and increasingly requires increased working across multiple disciplines to ensure safe standards of practice.

6.2.2 The current situation at LWH is potentially unsafe because of a lack of a full range of imaging services, the lack of a blood bank, the lack of Level 3 adult critical care services on site and poor access to colorectal surgery. The potential risks for women and babies are high.

6.2.3 The Cheshire and Mersey Critical Care Network is very clear that it would not be possible to create a sustainable effective small adult critical care facility at the Alder Hey site.

6.2.4 Neonatal Services at LWH are very good in spite of the cramped accommodation. Infection rates are unacceptably high. There are significant challenges in not being co-located with the neonatal surgical service at Alder Hey.

6.2.5 The panel noted that the North West Neonatal Operational Delivery Network 'strongly advocates the co-location of maternity, neonatal intensive care and paediatric subspecialty (including neonatal surgery) services' (reference Appendix 2 paragraph 4).
The Neonatal Network also appears to accept that it should be possible to have a single neonatal service working across two sites in Liverpool. A strong transfer service is currently in place and it should be noted across the UK small sick neonates with for example necrotising enterocolitis needing surgery are transferred from level 3 neonatal intensive care units to distant paediatric surgical units. Further work and investment is needed to ensure surgical input to LWH/RLH is enhanced and at the same time there would need to be investment to ensure that neonatal intensive care at Alder Hey was in place that could effectively care for the increased numbers of younger, more complex neonatal patients.

6.2.6 The development work outlined in 6.2.5 also needs to be addressed in the short term and Specialised Commissioning in NHS England could usefully do some further early work with LHW and Alder Hey neonatal services on transfer arrangements and risks involved by defining the speed of transfers needed for different conditions.

Post review note

The panel understands this work has commenced, jointly led by LWH and AH to develop and deliver the single service neonatal service across the two sites. It is anticipated that any capital and revenue implications will be considered as part of this work.

6.2.7 A split of Obstetrics and Gynaecology would not be supported by the review panel.

6.2.8 The dilemma faced by commissioners is that of reconciling a situation where currently the risks for women are on balance greater than the risks for neonatal patients (and this in no way underestimates both sets of risks). The views of the Operational Delivery Networks are key and differ, adding to the dilemma.

6.2.9 Further work is also needed to address staffing sustainability in Anaesthetics at LWH and Neonatal service at LWH and Alder Hey. For the latter even the considerable investment being considered may not be sustainable in the long term.

6.3 On balance the review panel agrees there is no ideal solution but, taking into account the differing views with each medical speciality, that the option to move LWH services to the RLH site offers the best sub optimal solution. In a city where there are two stand-alone new build hospitals (one for adults and one for children) with a lifespan of twenty years plus this would be the next best option to colocation (bringing adults and children's services together on one site) which is not possible in the short to medium term. Although not ideal, on the balance of risks, the panel agrees that option D3-N offers the most appropriate way forward.

6.4 In summary the review panel;

- Agrees with the validity of the case for change and the service change proposals.
- Considers option D3-N to be the most appropriate and sustainable of all four options.
- Considers the preferred option does support the strategic intent and policy direction of women's services nationally and women's and children's services locally.
- Does not consider the current 'workarounds' and inherent clinical risks to be sustainable.

Appendix 1

Independent Clinical Review

TERMS OF REFERENCE

Title: Review of services provided by Liverpool Women's NHS Foundation Trust

Sponsoring Commissioning Organisation: Liverpool Clinical Commissioning Group (LCCG)

Lead Clinical Senate: Northern England Clinical Senate

Terms of reference agreed by:

Roy McLachlan
on behalf of Northern England Clinical Senate and
Chris Grant and Helen Murphy
on behalf of LCCG

Date: 23 May 2017

Clinical Senate Review Team Members

Chair: Prof Andrew Cant, Chair Northern Clinical Senate, Consultant in Paediatric Immunology & Infectious Diseases, Newcastle upon Tyne Hospital NHS FT.

Derek Cruickshank, In Hospital Clinical Lead for BHP/STP & Secondary Care Doctor, Sunderland CCG (Formerly Consultant Gynaecology/Oncologist, James Cook University Hospital).

Sundeep Harigopal, Consultant Neonatal Paediatrician, Newcastle upon Tyne Hospital NHS FT.

Lesley Heelbeck, Head of Midwifery, Gateshead Hospital NHSFT.

Roy McLachlan, Associate Director Northern England Clinical Senate.

Robin Mitchell, Clinical Director NECN, formerly Consultant in Anaesthetics and Intensive Care Medicine.

Helen Simpson, Consultant Obstetrician, South Tees NHS FT.

Sharon English, Lead Clinician for Neonatal Services, Leeds Children's Hospital.

Gareth Hosie, Consultant Paediatric Surgeon, Newcastle Upon Tyne Hospitals NHS FT

Background Information

The purpose of the 'Review of Services Provided by Liverpool Women's NHS Foundation Trust' Pre-Consultation Business Case (PCBC) is to set out the options appraisal process and the resultant short list of reconfiguration options for public consultation, subject to approval from the Committees in Common. The PCBC sets out a compelling case for change with clear options for the future and provides a robust evidence base to proceed to consultation.

The rationale for considering how and where services are provided, and in particular the co-dependencies between services, is to ensure the long term viability of the provision of women's and neonatal services in Liverpool.

- There is a need to improve the health of people in Liverpool and ensure that healthcare services are meeting public expectations.
- The needs of the population are changing and LWH is being presented with more complex cases which have clinical inter-dependencies with other services that are not provided on the Crown Street site.
- An increasing number of patients, both mothers and babies are being transferred to acute sites across the city to ensure they get the best possible care to meet their needs. In the case of neonates, this can result in mother and baby being separated.
- Whilst services being provided at LWH are safe, this is due to workarounds being put in place and in the longer term a safer and more sustainable solution is required.
- There are workforce challenges as it is becoming increasingly difficult to recruit in some clinical specialisms such as neonatal care and anaesthetics and also to staff rotas.

This service review is focused primarily on assessing whether the ongoing provision of these services is best undertaken at the current LWH Crown Street site or whether another site or multiple sites in Liverpool might be better placed to provide these services in the future.

Aims and Objectives of the Clinical Review:

To ascertain using the clinical evidence base and clinical standards described in the PCBC work to date, whether the clinical case for change, option appraisal development and proposals for consultation offer the best clinical options for sustainable, high quality and optimal patient experience for future Liverpool Women's services.

Main Objectives of the Clinical Review:

- Assess the validity of the case for change and the service change proposals.
- Comment on the clinical appropriateness & sustainability (or not) of all four options in the PCBC.
- Consider whether the preferred option is aligned with the strategic intent and policy direction of women's services nationally and also sufficiently takes into account potential changes being planned in women and children's services in and around Liverpool given that LWH serves a wider population including Cheshire and Merseyside.
- Comment on the sustainability and clinical risk of the 'workarounds' currently in place and referenced in the PCBC.

Scope of the Review:

In Scope

The scope of the Senate review is to look at the clinical evidence base and options appraisal that underpin the options for public consultation.

The scope of this PCBC is the services that are currently provided by LWH from its hospital site on Crown Street – with the exception of fertility services which are currently provided at the Hewitt Fertility Centre (HFC) and the Genetics service, both of which will require consideration separately once a decision with respect to other services has been made.

The services in scope of this review therefore are:

- Consultant and midwife led obstetrics services;
- Gynaecology services including gynaecological oncology (cancer) services;
- Neonatal services.

Out of Scope

This review does not consider the organisational form of the future provider of women's and neonatal services in Liverpool. It was recently announced that the Boards of the RLBUHT, AUH and LWH had agreed in principle to the creation of one organisation. A business case for AUH and RLBUHT is under development for submission to NHSI, which must set out in detail the benefits to patients and how they will be achieved. The next steps for LWH in terms of this their organisational form will be considered following this review of the best way to deliver services.

Timeline:

May – July 2017

Reporting Arrangements

The clinical review team will report to the Northern England Clinical Senate Council which will agree the report and be accountable for the advice contained in the final report. The Clinical Senate Council will submit the report to the sponsoring organisation and this clinical advice will be considered as part of the NHS England assurance process for service change proposals.

Methodology

The clinical review team will look over the PCBC and all data and information provided by the CCG. The review team will come together for a half day with CCG representatives who will present the relevant sections of the PCBC and other pertinent evidence/data. This will be by way of preparing the review panel in advance of a visit to Liverpool. This visit will be a one day face to face meeting to discuss further the information received as a review panel and meet with the CCG clinicians and managers to clinically test out the PCBC. The review panel will also offer meet representatives of appropriate user engagement groups. The timeframe would be for CCG information to be circulated in May 2017 with the face to face meeting in Liverpool on Thursday 8 June 2017.

Key Process and Milestones

a. Finalise Terms of Reference 25 May 2017.
b. Information for review submitted by Commissioner and distributed to review team 17 May 2017.
c. Review panel to meet CCG representatives 25 May 2017.
d. Requests for clarification and/or further information from Commissioners 1 June 2017.
e. Panel review visit to Liverpool 8 June 2017.

Report

A draft clinical senate assurance report will be circulated within 15 working days from the face to face meeting by the clinical review team to the sponsoring organisation for factual accuracy.

Comments/correction to be received within 10 working days.

The final report will be submitted to the sponsoring organisation following the Northern England Senate Council meeting in July 2017.

Communication and Media Handling

The Clinical Senate aims to be open and transparent in the work that it does. The Clinical Senate would request that the sponsoring commissioning organisation publish any clinical advice and recommendations made.

All media enquiries will be handled by the sponsoring organisation.

Name of Communication Lead Sponsoring Commissioner: Helen Murphy

The detailed arrangements for any publication and dissemination of the clinical senate assurance report and associated information will be decided by the sponsoring organisation.

Resources

Administrative support to the review team, including setting up the meetings and other duties as appropriate, will be shared between the Clinical Senate and the sponsoring commissioner.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

Accountability and Governance

The clinical review team is part of the Northern England Clinical Senate accountability and governance structure.

The Northern England Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring commissioning organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

Functions, Responsibilities and Roles

The **sponsoring organisation** will:

I. Provide the clinical review panel with relevant information, this will include the PCBC in which is contained the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance, service specifications. LCCG will provide any other additional background information requested by the clinical review team.
II. Respond within the agreed timescale to the draft report on matter of factual inaccuracy.
III. Undertake not to attempt to unduly influence any members of the clinical review team during the review.
IV. Submit the final report to NHS England for inclusion in its formal service change assurance process.

Clinical Senate Council and the sponsoring organisation will:

I. Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical Senate Council will:

I. Appoint a clinical review team; this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
II. Advise on and endorse the terms of reference, timetable and methodology for the review.
III. Consider the review recommendations and report.
IV. Provide suitable support to the team.
V. Submit the final report to the sponsoring organisation.

Clinical Review team will:

I. Undertake its review in line the methodology agreed in the terms of reference.
II. Follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
III. Submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
IV. Keep accurate notes of meetings.

Clinical Review Team members will undertake to:

I. Commit fully to the review and attend all briefings, meetings, interviews, panels etc that are part of the review (as defined in methodology).
II. Contribute fully to the process and review report.
III. Ensure that the report accurately represents the consensus of opinion of the clinical review team.
IV. Comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare any potential conflicts, to the chair or lead member of the review panel.

‘How to optimise critical care for neonates on an adult site’

N. V. Subhedar, J. Maddocks, NW Neonatal ODN

Background

The Role of the North West Neonatal Operational Delivery Network (NWNODN) is to focus on coordinating neonatal pathways to ensure consistent, equitable access to high quality specialist neonatal care. Neonatal care delivery also needs to comply with national standards, including National Service Specifications for Neonatal Critical Care, Neonatal Surgery and Congenital Heart Disease.

The current configuration of services within Cheshire and Merseyside with a stand-alone maternity service site providing tertiary maternity care and a stand-alone tertiary paediatric service does not deliver optimal care for premature and sick babies who require these services. It is unlikely that these services will be co-located in the short- or medium-term.

The NWODN has recently completed projects that have recommended single service models for NW Transport, Neonatal Surgery (supported by neonatal critical care on the AH site) and Neonatal Intensive Care. These recommendations have been endorsed by the NWODN Board.

The NWODN strongly advocates the co-location of maternity, neonatal intensive care and paediatric subspecialty (including neonatal surgery) services to deliver the highest quality neonatal care to newborn babies requiring intensive care. This is the only configuration that is fully compliant with all national standards.

Mitigating risk for sick neonates on an adult site

What are the ways of mitigating risk for neonates if maternity/neonatal care is not co-located with paediatric specialties at AH?

1. Safety
    - Minimising neonatal transfers by ensuring urgent on-site access to paediatric specialist services (including general surgery), investigations (including imaging) and treatments (e.g. mobile ECMO).
    - Improving timely access to transport services.
    - Improving access to on-site paediatric pathology services.

2. Quality
    - Improving access to non-urgent specialist reviews (including various paediatric subspecialists, allied health professionals, psychologists) and specialist investigations.
    - Establishment of on-site MDT meetings, including extending joint antenatal counselling sessions.
    - Minimising separation of mothers and babies by facilitating early discharge of mothers with provision of postnatal care/accommodation at AH.
    - Better use of telemedicine links with AH for clinical and non-clinical indications.

Appendix 3

Cheshire & Mersey Major Trauma
Operational Delivery Networks

Re: LWH options and adult critical care requirements

Since its inception (in 2000)) of Cheshire & Mersey Critical Care Network (CMCCN) (latterly Cheshire & Mersey Adult Critical Care Operational Delivery Network) has worked with the staff of LWH to improve their identification and management of acute deterioration/critical illness in pregnant and recently delivered women.

The location of LWH services without direct access to the full facilities of an acute general hospital, including direct access to level 3 care (intensive care) has posed clinical and logistical problems and presents an increasing level of clinical risk.

At the request of LCCG CMCCN has provided the following points of clarification relevant to the options contained in this pre-public consultation business case:

The preferred option stated (relocation to the new Royal Liverpool Hospital site with a direct physical link) is the only one of the four which will provide LWH acute obstetrics and gynaecology services with direct access to the full range of acute services and associated facilities required to care for acutely deteriorating/critically ill women. This must include 24/7 provision of adult level 2 and level 3 critical care on-site.

The other options under consideration do not meet the standards required for provision of adult critical care. Due to the geographical situation and specialist nature of the LWH Crown Street site and the Alder Hey Hospital these options will be unable to comply with the standards required for provision of level 2 and level 3 adult critical care.

The standards required for provision of adult critical care (level 2 and level 3) include:

- Co-dependent adult acute care services cognisant with an acute general hospital [1, 2, 3, 4]. This includes 24/7 acute medical, surgical and anaesthetics services as well as support services and diagnostics.
- Sufficient and sustainable multi- professional staff competent to deliver level 2 and level 3 critical care on-site 24/7 [1, 2, 3, 4].
- Critical care (level 2 and 3) is delivered by a full multi-disciplinary team and should meet education and training standards for the specialty (critical care) and those professional groups [1, 2, 3, 4].

Any change to adult critical care facilities in Cheshire & Mersey requires clinical approval of the relevant business case from the Cheshire & Mersey Joint Operational Delivery Networks Board. Other than the stated preferred option (relocation to the new Royal Liverpool Hospital site with a direct physical link) the options contained in the pre-consultation business case will not meet the required standards [1, 2, 3, 4] and subsequently would not receive this approval.

CMCCN has also been asked to provide consideration of 'small' critical care units (< 6 adult critical care beds). Although these do still exist in the UK they have the following disadvantages (not in any particular order):

- High quality critical care benefits from exposure to best practice and innovation; small units are less likely to be able to provide this
- Unlikely to attract or retain experienced staff
- Unlikely to meet education and training requirements for medical and nursing staff
- Not cost effective and lacks flexibility
- Would not be commissioned due to the requirement to be compliant with national standards [2, 3, 4].

In addition sophisticated clinical governance processes are required to deliver high quality critical care; these are much harder, if not impossible to deliver in a small unit geographically separate from an acute adult general hospital as proposed in the Crown Street and Alder Hey options.

Within the NW small critical care units have closed because they were unsustainable (for example Halton, Chorley) with others' sustainability in question.

LWH does not comply with the standards for level 3 critical care provision [1, 2, 3, 4] and is at increasing risk of not being able to provide level 2 critical care. Women requiring level 3 critical care need to be transferred to another hospital, itself a high risk clinical activity.

CMCCN and CMMTN (Cheshire & Mersey Major Trauma Operational Delivery Network) in collaboration with Cheshire & Mersey Neonatal Network (part of the North West Neonatal Operational Delivery Network) and Cheshire & Mersey Strategic Clinical Networks (now North West Coast Strategic Clinical Networks) have produced pathways for the acutely ill/critically ill woman[6] and the pregnant major trauma patient[7] to try to streamline the complex pathways resulting from the geographically separate location of specialist acute services across Liverpool and mitigate against further serious clinical incidents, as far as possible given the current situation.

Failure to relocate LWH to an adult acute hospital site (a direct physical link for patient trolley/bed transfer is essential) would severely worsen the already precarious situation for acutely ill/critically ill women at LWH and as a newly commissioned service would carry prohibitive risk.

References

1. CMCCN Service Specification for Adult Critical Care (incorporating D5) (2016)
2. D5 National Clinical Reference Group Service Specification for Adult Critical Care (2016)
3. 20160607 900472 NHS Critical Care Core Service Framework v1 08 (Published on internet July 2016) Care Quality Commission assessment tool for adult critical care (2016)
4. Guidelines for the Provision of Intensive Care Services (GPICS) (2015) https://www.ficm.ac.uk/sites/default/files/GPICS%20-%20Ed.1%20(2015)_0.pdf
5. Enhanced Care for the Sick Mother Standards in Maternal Critical Care (Joint Royal Colleges and Intensive Care Society, final draft, 2016)
6. Acutely Unwell/Critically Ill Pregnant or Recently Pregnant Woman (2015)
7. Pregnant Major Trauma Pathway (2015)

Sarah Clarke
Director & Lead Nurse
CMCCN

October 2016

Appendix 4

NHS
Liverpool
Clinical Commissioning Group

Review of services provided by Liverpool Women's NHS Foundation Trust

Northern Clinical Senate
25th May 2017

Healthy Liverpool Programme
Hospital Transformation Team

NHS
Liverpool
Clinical Commissioning Group

- Dr Fiona Lemmens – Clinical Director
- Dr Chris Grant – Programme Director
- Helen Murphy – Programme Manager

Healthy Liverpool Programme

NHS
Liverpool
Clinical Commissioning Group

A health care system in Liverpool that is person-centred, supports people to stay well and provides the very best in care

Case for Change

NHS
Liverpool
Clinical Commissioning Group

Poor Health

30% of people in Liverpool live with one or more long-term conditions.

Lifestyle

Over half of adults in Liverpool are overweight or obese.

93,000 people in Liverpool are affected by mental health issues.

Health Inequalities

Men in Liverpool live 3.1 years less and women 2.8 years less than the England average.

The difference in life expectancy between areas of the city can vary by more than 10 years.

Case for Change

NHS
Liverpool
Clinical Commissioning Group

Ageing population

By 2021 there will be 9% (5,700) more people living beyond the age of 65 with the biggest growth in those aged 70-75 and 85+.

Almost 26,000 older people have a long-term illness that limits their day-to-day activities a lot.

By 2021 there will be a 10.7% increase in the number of people living with dementia.

Access and Variation

The number of people with diabetes receiving the recommended care processes to manage their condition varies between 20% and 80% depending on where they live in Liverpool.

The number of patients with Chronic Obstructive pulmonary disease offered rehabilitation varies between 24% and 79% in the city.

Healthy Liverpool animation

NHS
Liverpool
Clinical Commissioning Group

Healthy Liverpool Journey

NHS
Liverpool
Clinical Commissioning Group

- NHSE Assurance Process
- Clinical Senate Review
- OSC engagement
- NHS Improvement

Mayoral Health Commission
January 2014

Clinical Summit
November 2014 — Clinicians across the city leading change

Healthy Liverpool - Prospectus for Change
November 14

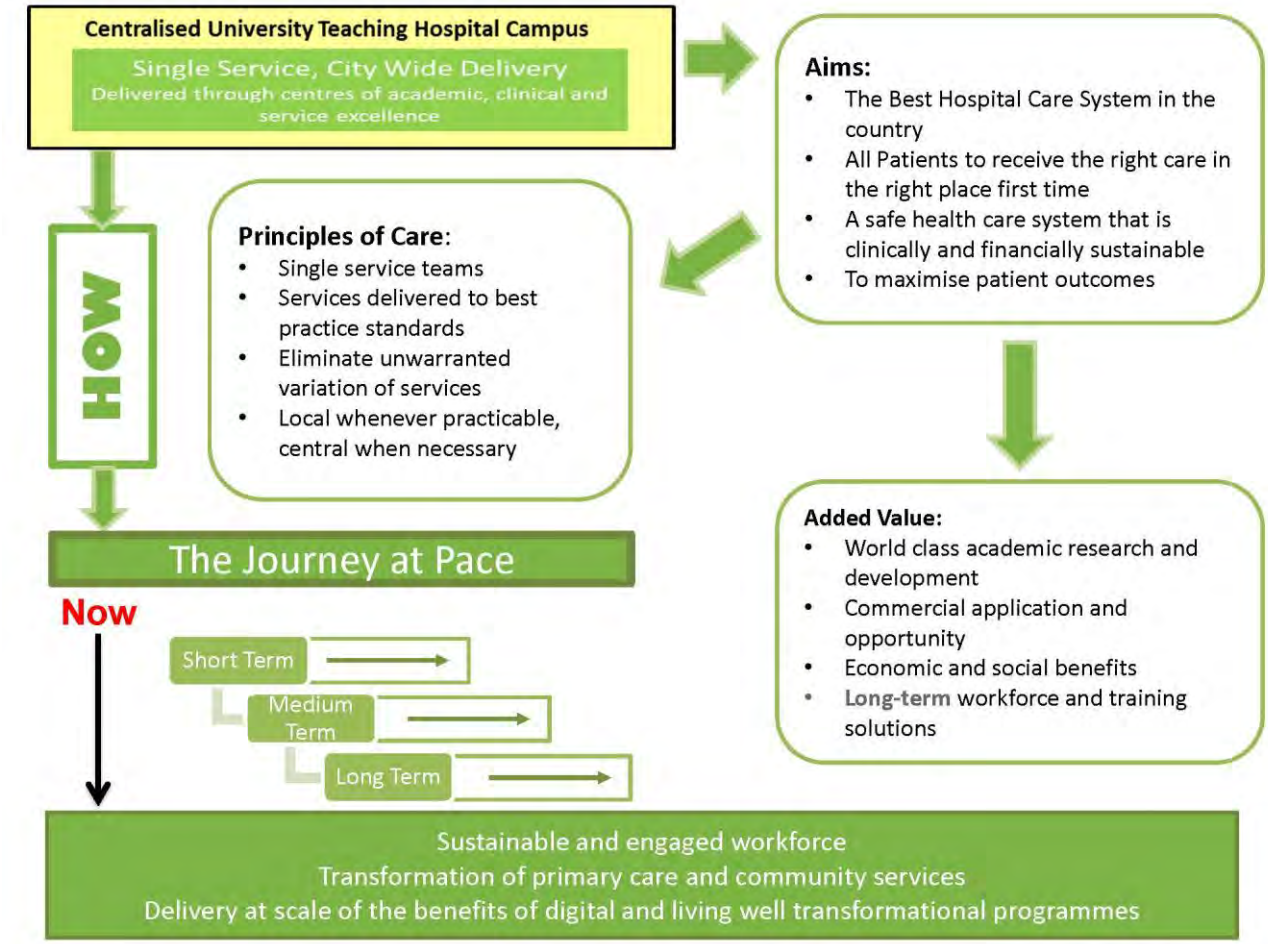
Hospital Transformation Clinical Summit
July 15 — Single Service, System Wide Delivery

Healthy Liverpool Blueprint
November 2015

Pre-consultation Engagement
January 2016 — Healthy Liverpool - Single Service

LWH Review – Pre-consultation Engagement
Summer 2016

Formal Consultation – Single Service
July 2017



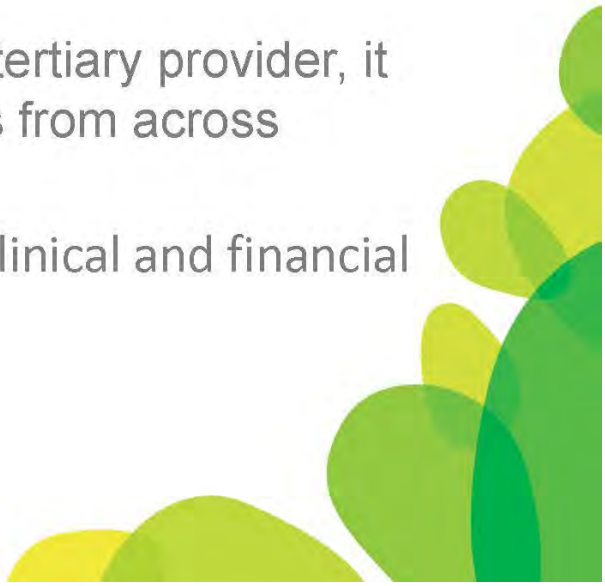
NHS
Liverpool
Clinical Commissioning Group

Liverpool Women's NHS Foundation Trust

Liverpool Women's NHS Foundation Trust

NHS Liverpool Clinical Commissioning Group

- Gynaecology, obstetrics, genetics, fertility treatment and neonatal services at the Crown Street site
- As the regional specialist tertiary provider, it serves women and babies from across Cheshire & Merseyside
- The review it is to secure clinical and financial sustainability



Liverpool Women's NHS Foundation Trust

NHS Liverpool Clinical Commissioning Group

- LWH is one of only two stand alone specialist Trust's in the country providing care exclusively to women and babies
- In 2015/16 LWH delivered over 8600 babies
- Provided gynaecological care to over 5800 patients
- Delivered intensive care to over 1000 babies

NHS
Liverpool
Clinical Commissioning Group

Liverpool Women's NHS Foundation Trust

Case For Change

Healthy Liverpool animation

NHS
Liverpool
Clinical Commissioning Group

"why women's and new-borns' services need to change"

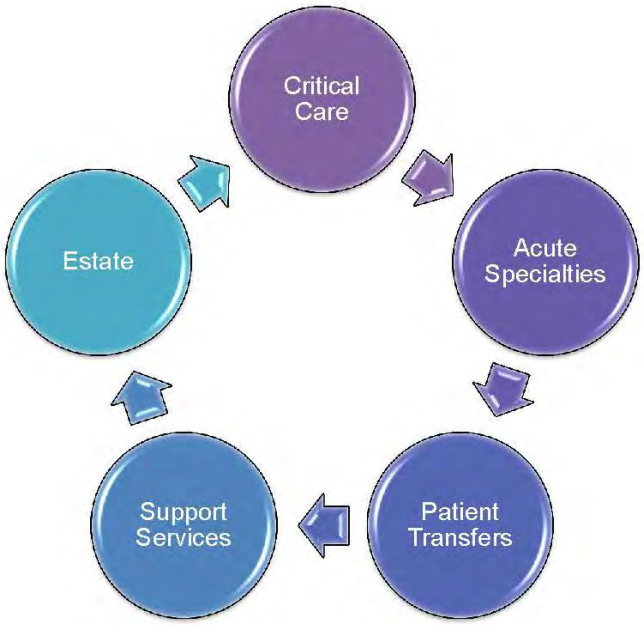
Case for Change

NHS
Liverpool
Clinical Commissioning Group

Need to improved the health of people in Liverpool and ensure that healthcare services are meeting public expectations	Needs of the population changing – more complex cases which have clinical interdependences that aren't available at LWH	Increase number of patients being transferred to acute sites across the city – Separating Mothers and Babies
Whilst services at LWH are safe this is due to workarounds – a long term solution is required	Workforce challenges as it is becoming increasingly difficult to recruit in some clinical specialisms	The case for change is clinically rather than financially driven, however LWH is financially unstable in its current form

Clinical Case for Change

NHS
Liverpool
Clinical Commissioning Group



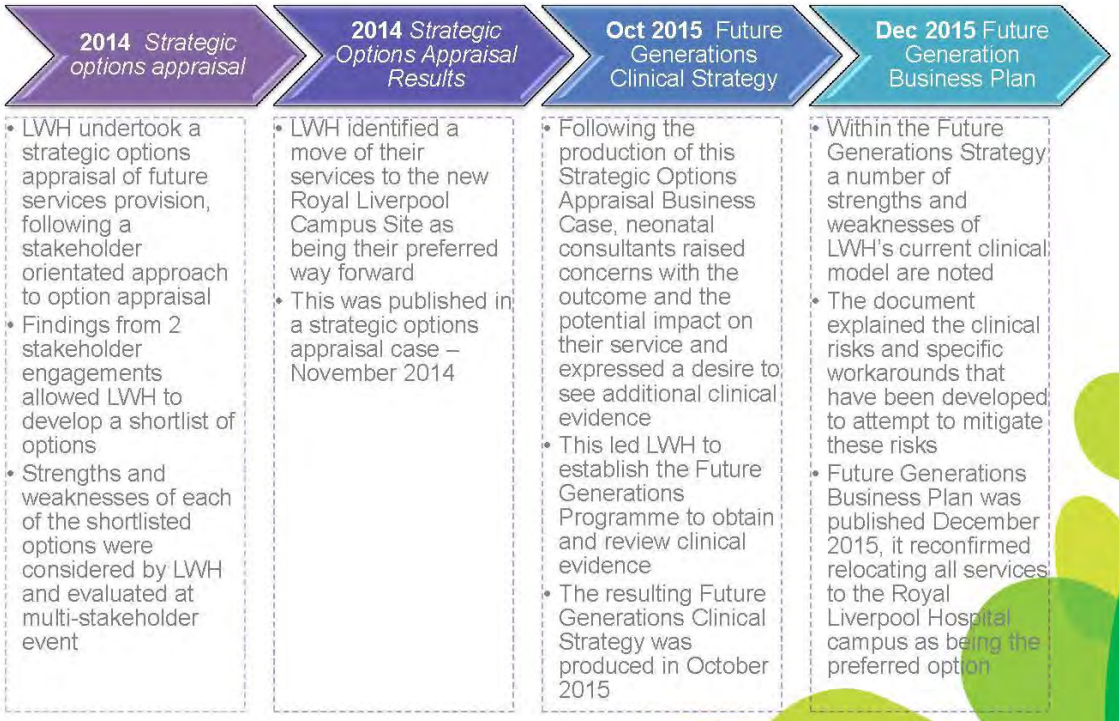
NHS
Liverpool
Clinical Commissioning Group

Liverpool Women's NHS Foundation Trust

Future Generations Strategy

Liverpool Women's NHS Foundation Trust

NHS
Liverpool
Clinical Commissioning Group



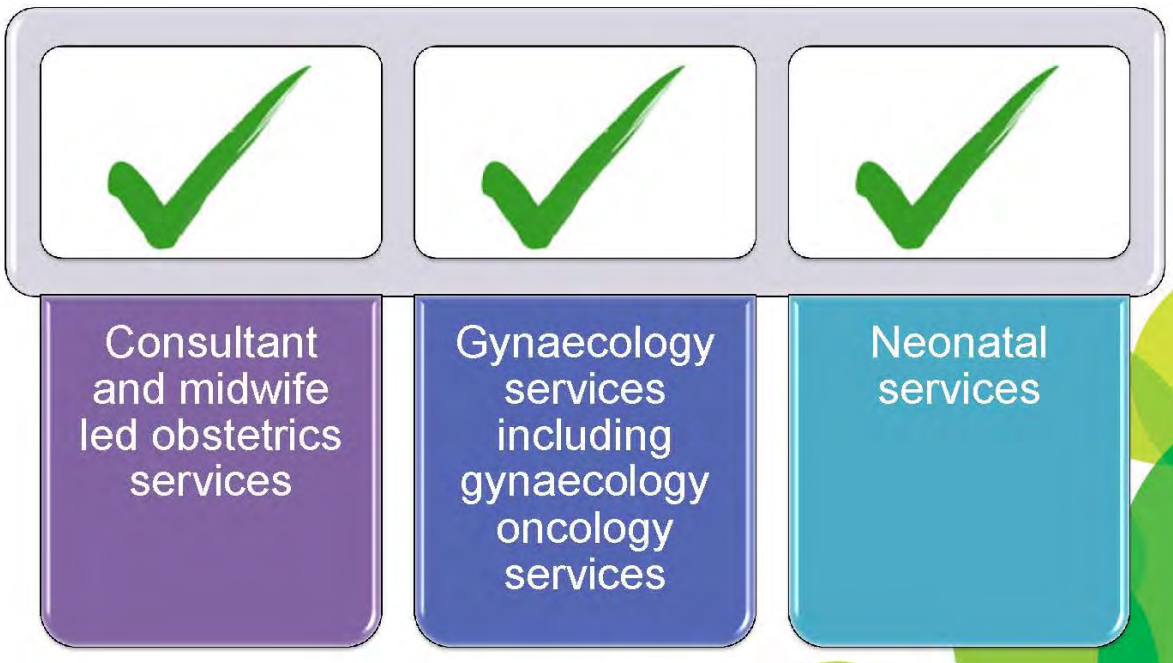
NHS
Liverpool
Clinical Commissioning Group

Liverpool Women's NHS Foundation Trust

Commissioner led review

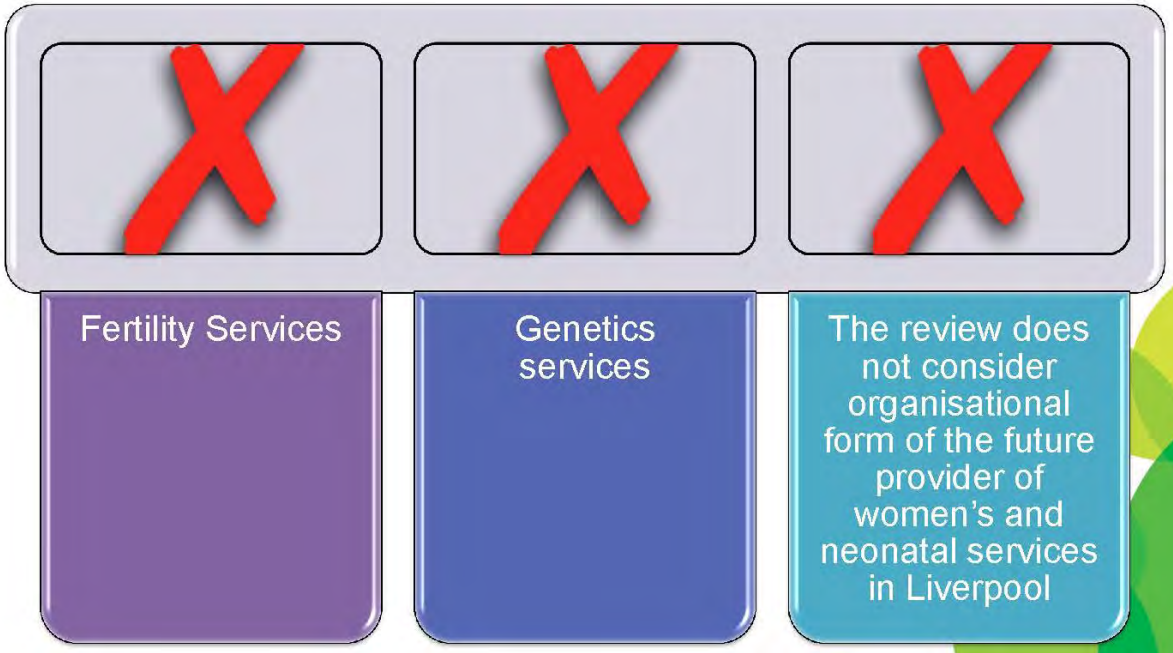
NHS
Liverpool
Clinical Commissioning Group

Services in Scope of this Review



Services out of scope

NHS Liverpool Clinical Commissioning Group



Process

NHS Liverpool Clinical Commissioning Group

Key Meetings

- Options Development workshops – supported by FTI Consulting
- Clinical Reference Group – chaired by Dr Mike Bewick
- Programme Oversight Board – chaired by Dr Andrew Loughney
- Estates workshops

Options Appraisal Process

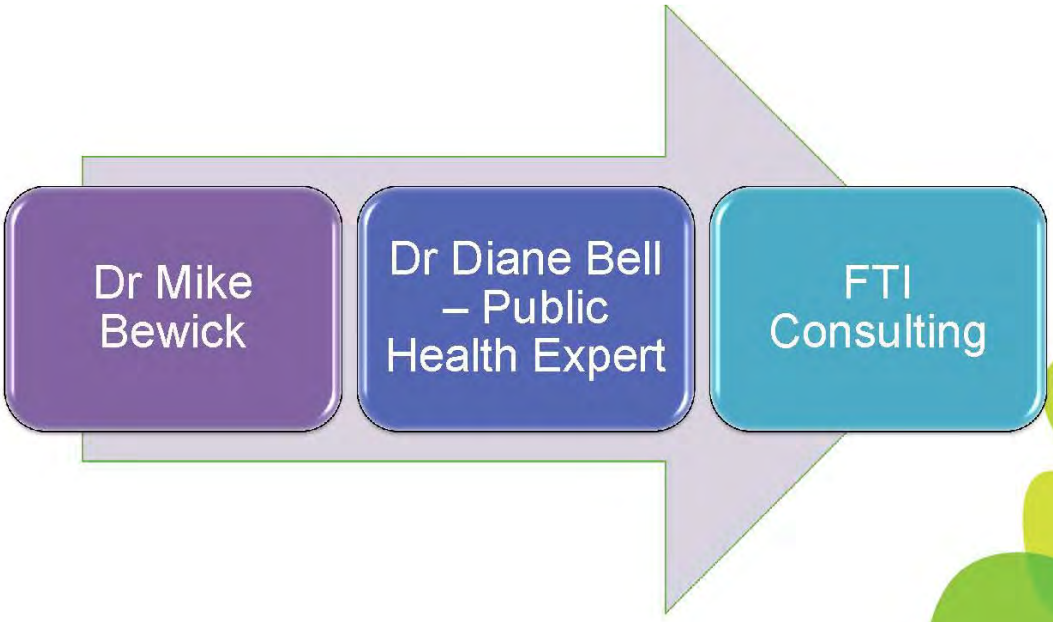
- Critical Success factors
- Weightings
- Workshops
- Long list
- Short list

Key Stakeholders

NHS Liverpool Clinical Commissioning Group

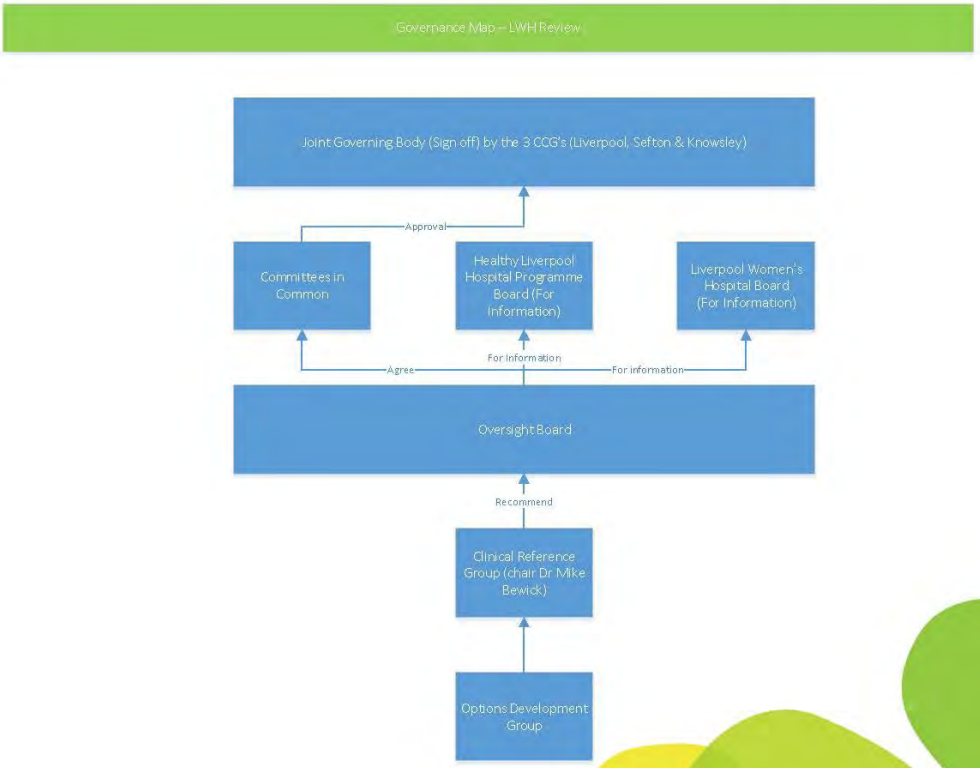
The external review team

NHS Liverpool Clinical Commissioning Group



Governance

NHS Liverpool Clinical Commissioning Group



Meetings of Key Working Groups

NHS Liverpool Clinical Commissioning Group

NHS
Liverpool
Clinical Commissioning Group

Liverpool Women's NHS Foundation Trust

Commissioner led review – Pre-consultation Engagement

Pre-consultation engagement
June 2016

NHS
Liverpool
Clinical Commissioning Group

- 72% supported the Case for Change
- The majority supported the clinical issues and changing needs of patients as the two key reasons for change
- When asked to chose from a list of six reasons for change 'patient safety and high quality of care' and 'having a good experience of care' were selected as the two priorities by the public
- Issues raised as important by those engaged were; Having a dedicated women's hospital in Liverpool, lack of ICU at crown street and all care being delivered under one roof

Common themes from community groups:

NHS Liverpool Clinical Commissioning Group

- Attendees wanted to see the Crown Street site built upon and improved
- Those engaged respected and were ready to support the clinicians' reasons for change
- There was some concern that the reasons for change may focus on critical cases rather than the needs of the majority of the patients

NHS Liverpool Clinical Commissioning Group

Liverpool Women's NHS Foundation Trust

Commissioner led review – Developing the Options Appraisal Framework

Options Appraisal Process

NHS
Liverpool
Clinical Commissioning Group

Developing the Critical Success Factors

NHS
Liverpool
Clinical Commissioning Group

- A critical success factor should reflect something that is a **Key priority for the service reconfiguration.** The option can then be tested against that priority to see how well it meets the criteria.
- In addition, CSFs should allow options to be **differentiated** from each other i.e. there is no point including CSFs that all options will meet with equal scoring.
- However if there is a minimum standard, then this should be considered a **'hurdle'** criteria that would rule an option out at an earlier stage.
- CSFs should also reflect **range of priorities** for the service reconfiguration and therefore we tend to consider CSFs under four categories:

The Critical Success Factors

NHS Liverpool Clinical Commissioning Group

Category	CSF #	Description
Quality 35%	1	The proposed option will maintain or improve the health and wellbeing of the whole population receiving services
	2	The proposed option will allow services to maintain or improve clinical outcomes and maintain or exceed clinical standards
	3	The proposed option will allow services to deliver a positive patient experience for patients and their families
	4	The proposed option will improve clinical sustainability
	5	The proposed option will increase scope for research and innovation
Feasibility 20%	6	Recognise current and future workforce requirements and allow for appropriate education and training
	7	Include plans for sufficient estate for delivery of optimal services now and in the future
	8	Be likely to be acceptable to patients, families and the wider public
Financial Sustainability 30%	9	The proposed option contributes to achievement of recurrent financial sustainability for all services
	10	The proposed option is financially deliverable given likely funding constraints
Strategic Fit 15%	11	The proposed option aligns with the goals of the Healthy Liverpool Programme
	12	The proposed option supports delivery of local, regional and national policy

Weightings

NHS Liverpool Clinical Commissioning Group

- The options were scored in each CSF (and sub criteria) leading to and overall score per CSF category
- An overall assessment of each option was then determined, using a weighting to assess the relative importance of the criteria
- The weighting used is shown here.
- We also performed a sensitivity analysis as part of the options appraisal process, to understand how a change in the weightings might affect the overall outcome.

Category	Weighting
Quality	35%
Feasibility	20%
Financial sustainability	30%
Strategic fit	15%

NHS Liverpool Clinical Commissioning Group

Liverpool Women's NHS Foundation Trust

Commissioner led review – The Options

Extended long list of options

NHS Liverpool Clinical Commissioning Group

No.	Description	Long list?	Rev. No.
1	Do nothing	√	A
2	Develop a community-based local maternity network supported by specialists and acute providers in Liverpool	√	B
3	Develop and enhance existing LWH services	√	C
4	Relocate all services to AH	√	D1
5	Relocate all services to RLH	√	D3
6	Relocate all services to AUH	√	D2
7	Develop a new 'greenfield super hospital'	X	
8	Deliver elective gynaecology at LWH / Relocate non-elective gynaecology to RLH / Relocate obstetrics and neonatal services to AUH	X	
9	Relocate gynaecology to AUH / Deliver obstetrics and neonatal services at LWH	√	E1
10	Relocate gynaecology to AUH / Relocate obstetrics and neonatal services to AH	√	F1
11	Relocate gynaecology services to RLH / Deliver obstetrics and neonatal services at LWH	√	E2
12	Deliver gynaecology at LWH / Relocate obstetrics and neonatal services to AH	X	
13	Relocate gynaecology to RLH / Relocate obstetrics and neonatal services to AH	√	F2
14	Relocate gynaecology to RLH / Relocate obstetrics and neonatal services to AUH	X	
15	Relocate gynaecology to AUH / Relocate obstetrics and neonatal services to RLH	X	
16	Develop a surgical delivery suite at AH with a NICU for immediate surgical or cardiac input	X	
17	Develop a Merseyside maternity network	X	
18	Non-NHS provision of services	X	
19	Deliver gynaecology services at LWH / Relocate obstetrics and neonatal services to Broadgreen Hospital	X	
20	Relocate all services to Broadgreen Hospital	X	

Clinically led long list of options

NHS Liverpool Clinical Commissioning Group

Rev. No.	Description of option
C	Develop and enhance the Crown Street site
D1	Relocate all services to AH
D2	Relocate all services to AUH
D3	Relocate all services to the RLH site
E1	Relocate gynaecology to AUH while obstetric and neonatal services remain at an enhanced Crown Street
E2	Relocate gynaecology services to the RLH site while obstetric and neonatal services remain at an enhanced Crown Street
F1	Relocate obstetrics and neonatal services to AH and gynaecology to AUH
F2	Relocate obstetrics and neonatal services to AH and gynaecology to the RLH site

Final Options for Public Consultation

NHS Liverpool Clinical Commissioning Group

Option	Summary description
C1: Develop and enhance LWH's current Crown Street site.	The services that are currently envisaged to be part of an 'enhanced Crown Street' include: an adult ICU; blood bank; improved access to diagnostics including staff to deliver CT/MRI scans on site or in a mobile format; additional IR services; and neonatal support services.
C2: Provide minimal upgrades to LWH's current Crown Street site to enable safer care and minimise emergency transfers.	This option will involve a minimum enhancement to the existing services provided at Crown Street. A blood bank will be provided and a CT scanner leased. Upgrades to the existing neonatology service will be made.
D1: Relocate all services to the AH site (new build).	All services currently provided on the Crown Street site will relocate to AH. The relocated services will be located in a new building on the AH site.
D3-N: Relocate all services to the new RLH site (new build).	All services currently provided at the Crown Street site will move to the new RLH site, as a new build. This is the preferred option identified in LWH's previous Business Case.

Where are we now?

NHS Liverpool Clinical Commissioning Group

- NHS England stage 2 assurance identified a financial case is required to show how this will be funded
- LWH working with NHS I on an outline business case
- Finance Oversight Board established – NHS E and NHS I in attendance
- Timescales for outline business case to be completed – end July 2017
- NHS E assurance process – following OBC
- Formal public consultation – following stage 2 assurance NHS E

Objectives of the Clinical Senate Review

NHS Liverpool Clinical Commissioning Group

- Assess the validity of the case for change and the service change proposals
- Comment on the clinical appropriateness and sustainability of all four options in the PCBC
- Consider whether the preferred option supports the strategic intent and policy direction of women's services nationally and women and children's services locally
- Comment on the sustainability and clinical risk of the 'workarounds' currently in place and referenced in the PCBC

Parallel pieces of work

NHS
Liverpool
Clinical Commissioning Group

- Improving Me - Cheshire and Merseyside Women's and Children's Services Vanguard
- NWNODN review
- LWH Operational Plan 2017-18

Concerns / Politics

NHS
Liverpool
Clinical Commissioning Group

- What haven't we told you
- Campaign groups
- Stakeholders


NHS
Liverpool
Clinical Commissioning Group
Questions & Discussions

NHS Liverpool Clinical Commissioning Group

ITINERARY – LWH Women's and Neonatal Review

Title: **CLINICAL SENATE REVIEW**
Date: **Thursday 8 June 2017**
Time: **8.00am – 4.30pm**

Time	Item	Location	Details
08:00	Arrival at LCCG	LCCG, Lewis's Building, Renshaw Street, L1 2SA	Senate panel members to meet with Chris Grant, Fiona Lemmens and Helen Murphy at LCCG reception, 3rd Floor. Meeting room 2 reserved for the day and can be used to leave bags, etc whilst off-site.
08:10	Travel to LWH		Taxi to collect from front of Watson Building (to the right of LCCG as you leave the main entrance)
08:20	Arrival at Liverpool Women's NHS FT	LWH, Crown Street L8 7SS	Met by Devender Roberts and Jeff Johnson
08:30	Introduction	Large Meeting Room	**Associate Medical Director** – Devender Roberts **Executive team** – Vanessa Harris Director or Finance Jeff Johnston – Director of Operations Michelle Turner - Director of OD & Workforce Doug Charlton – Director of Nursing & Midwifery **Deputy Director of Nursing & Midwifery** Julie King **Deputy Director of Finance** Jenny Hannon

NHS Liverpool Clinical Commissioning Group

8:40	Obstetric Risks on an isolated site - Including Q&A	Large Meeting Room	Clinical Director for Maternity - Mark Clement Jones Interim Head of Midwifery – Fiona Bryant Governance Facilitator – Sian McNamara
9:40	Neonatal Risks on an isolated site - Including Q&A	Large Meeting Room	Clinical Director for Neonates – Bill Yoxall Head of Neonates – Jennifer Deeney
10:40	**Refreshments**		
10:55	Gynaecological Risks on an isolated site - Including Q&A	Large Meeting Room	Clinical Director for Gynaecology John Kirwan Nursing Lead
11:25	Anaesthetic and Theatre Risks on an isolated site - Including Q&A	Large Meeting Room	Clinical Director for Anaesthetics - Edwin Djabatey Nursing Lead ODA
11:55	Clinical Tour	Neonatal Unit Delivery Suite HDU Facilities	Devender Roberts Bill Yoxall Ed Djabatey
12:30	**Working Lunch**	**Large Meeting Room**	
13:30	Travel back to LCCG		
13:45	Meetings with Alder Hey staff	Meeting room 2, LCCG, Lewis's Building, Renshaw Street, L1 2SA	**Medical Director** - Steve Ryan **Associate medical director** - Graham Lamont **Consultant Urologist** - Harriett Corbett **Consultant Paediatric Surgeon** - Jo Minford **Director of Strategy** - Debbie Herring
14:45	Panel time	Meeting room 2, LCCG, Lewis's Building, Renshaw Street, L1 2SA	
15:45	**Refreshments**		
16:00	Feedback	Meeting room 2, LCCG, Lewis's Building, Renshaw Street, L1 2SA	
16:30	**Close of day – travel to Lime Street Station for train at 17:10**		

Appendix 6

LWH Review List of Attendees Thursday 8th June 2017

Attendees
LWH Mark Clement Jones - Clinical Director for Maternity Fiona Bryant Interim - Head of Midwifery Sian McNamara - Governance Facilitator Jenny Buldon -
LWH Bill Yoxhall - Clinical Director for Neonates Jennnifer Deeney - Head of Neonates Sue O'Neil - Chris Stewart - Val Irving -
LWH John Kirwan - Clinical Director for Gynaecology Chris McGale - Nursing Lead
LWH Edwin Djabatey - Clinical Director for Anaesthetics Nicky Maggs - Nursing Lead
Alder Hey Steve Ryan - Medical Director Graham Lamont - Associate Medical Director Harriet Corbett - Consultant Urologist Jo Minford - Consultant Paediatric Surgeon Debbie Herring - Director of Strategy

Agenda Item	**17/286**

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Board Assurance Framework**
DATE OF MEETING:	Friday, 06 October 2017
ACTION REQUIRED	**For Approval**
EXECUTIVE DIRECTOR:	Doug Charlton, Director of Nursing and Midwifery
AUTHOR(S):	Alan Clark, Patient Safety Programme 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 **2.** Operational Plan **3.** NHS Compliance	☒ ☒ ☒	**4.** NHS Constitution **5.** Equality and Diversity ***6.*** Other: **34T**	☒ ☒
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 proposed changes to BAF***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		All Board Committees	
	Date of meeting		Various	

Executive Summary

Following the revision of the Board Assurance Framework (BAF), the Board sub-committees have considered the BAF risks within their remit to determine if any recently completed actions or changes in circumstances, mitigation and controls warrant an adjustment of the associated risk scores. They have also considered whether related Corporate and Service risks require escalation for monitoring or for enabling decisions or resources.

Only one sub-committee has advised of changes to any risks following their deliberations.

The Putting People First (PPF) Committee considered as a result of earlier discussions, that the national shortage of junior doctors is becoming an increasing risk to the Trust, alongside a gap of specialist nursing roles. It was recommended that the corporate risk 1743 be increased to a score of 20 (5x4) and escalated to the Board Assurance Framework.

The Committee are asked to consider this proposal and to decide if this risk should be accepted onto the Board Assurance Framework for Board monitoring and review.

Report

1. Introduction

Following revision of the Board Assurance Framework, this report seeks to inform the committee of any changes in risk score or escalation / de-escalation proposals made by sub-committees after consideration of risks within their remit.

2. Proposed Changes to Risks

The Board sub-committees have reviewed the risks within their remit and proposed only one change, as described below:

Sub-committee / Exec Lead	Risk No.	Description	Current Risk Score	Proposed Change	Rationale
Putting People First Exec Lead: Michelle Turner	Corporate Risk No.1743	Risk: Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have staff with the capability and capacity to deliver the best care	5x3	Risk Score increased to 20 (consequence 5xLikelihood 4). Escalated to BAF	Whilst the committee received some assurance of actions in place to mitigate the decline in junior doctor staffing, it concluded that the national shortage of junior doctors is becoming an increasing risk to the Trust, alongside a gap of specialist nursing roles. It was recommended that the corporate risk 1743 be increased to a score of 20 and escalated to the Board Assurance Framework.

The current BAF (appendix 1); the proposed changes are highlighted in yellow.

3. New Risks and Closed Risks

No new risks were identified nor were any risks closed as a consequence of sub-committee review.

4. Conclusions / Recommendations

The Executive committee are asked to:

1. Consider the proposal(s) within this report and decide if they are accepted.
2. Advise the Governance team of the decision to enable them to ensure it is reflected on the Ulysses system.

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

Risk Appetite: Moderate

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

CQC Domain: Well-Led

Enabling Strategy: Putting People First Strategy

Executive Lead: Michelle Turner

Operational Lead: Susan Westbury

Assurance Committee: PPF

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

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

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

Risk Appetite: Moderate

Objective: Long-term financial sustainability

CQC Domain: Well-Led / Effective

Enabling Strategy: Strategic Options Appraisal

Executive Lead: Vanessa Harris

Operational Lead: Jenny Hannon

Assurance Committee: FPBD

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

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

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

Objective: Deliver the annual financial plan

Executive Lead: Vanessa Harris

CQC Domain: Well-Led / Effective

Operational Lead: Jenny Hannon

Enabling Strategy: Operational Plan

Assurance Committee: FPBD

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

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

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

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

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

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

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

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

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

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

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

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

Strategic Objective: To deliver **safe** services

Risk Appetite: Low

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

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

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

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

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

Risk Appetite: Moderate

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

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

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

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

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

Risk Appetite: LOW

Objective: A positive patient experience

CQC Domain: Experience

Enabling Strategy: Quality Strategy / Patient Experience Strategy

Executive Lead: Doug Charlton

Operational Lead: Julie King

Assurance Committee: GACA

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

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