Meeting of the Board of Directors
HELD IN PUBLIC
Friday 6 April 2018 at 1000hrs
Liverpool Women's Hospital
Board Room

Item no. 2018/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
	Thank you	To provide personal and Team thank you – above and beyond			1000 (10mins)	caring
089	Apologies for absence Declarations of interest	Receive apologies	Verbal	Chair		-
090	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		Well Led
091	Patient Story	To receive a patients story	Presentation		1010 (20mins)	Safe, Experience, Well led
092	Minutes of the previous meeting held on 2 March 2018	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1030 (5mins)	Well Led
093	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written/verbal	Chair		Well Led
094	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1035 (10mins)	Well Led
095	Chief Executive Report • Gender Pay Report • National Workforce Strategy Trust response	Report key developments and announce items of significance not elsewhere	Written /Verbal	Chief Executive	1045 (10mins)	Well Led

Item no. 2018/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
BOARD COMMITTEE ASSURANCE						
096	Chair's Report from Quality Committee and Terms of Reference	Receive assurance and any escalated risks	Written	Committee Chair	1055 (15mins)	Well Led
097	Chair's Report from Finance, Performance and Business Development Committee and Terms of Reference	Receive assurance and any escalated risks	Written	Committee Chair		Well Led
098	Chair's Report from the Audit Committee and Terms of Reference	Receive assurance and any escalated risks	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						
099	Annual Staff Survey 2017	Receive assurance and any escalated risks	Written / Presentation	Director of Workforce and Marketing	1110 (20mins)	Well Led
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES						
100	Safer Nurse/Midwife Staffing Monthly Report 11	Receive assurance and any escalated risks - The Board is asked to note the content of the report	Written	Acting Director of Nursing and Midwifery	1130 (5mins)	Safe Well Led
101	Performance Report period 11, 2017/18	Review the latest Trust performance report and receive assurance	Written	Director of Operations	1135 (10mins)	Well Led
102	Finance Report period 11, 2017/18	To note the current status of the Trusts financial position	Written	Director of Finance	1145 (10mins)	Well Led
TRUST STRATEGY						
BOARD GOVERNANCE						
103	Board Assurance Framework	Receive assurance and any escalated risks against corporate risks	Written	Trust Secretary	1155 (5mins)	Well Led

Item no. 2018/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
104	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair		Well Led
HOUSEKEEPING						
105	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1200 Meeting ends	Well Led

Date, time and place of next meeting Friday 4 May 2018

Meeting to end at 12:00

1200-1215	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 of Directors

Minutes of the meeting of the Board of Directors
held in public on Friday 2 March 2018 at 1000 hrs
at Liverpool Women's NHS Foundation Trust, Crown Street Liverpool.

PRESENT

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

IN ATTENDANCE

Mr Colin Reid	Trust Secretary

APOLOGIES

2018	
	Thank You The acting Director of Nursing and Midwifery provided a thank you to the Safeguarding Team. She advised that the team had been on a difficult journey over a number of years and were now a shining light in the provision of the safeguarding services at the Trust. She thanked the representatives present. The Director of Operations provided a thank you on behalf of the Board to the five members of staff that work on the Gynaecology Unit and who had volunteered to work for three weeks to support Southport and Ormskirk Hospitals NHS Trust during the winter pressures. The Director of Operations thanked: Julie Copeland and Sarah Moss, both registered nurses; and support staff Janet Dorian, Tracy Mitchell and Michaela Maher. The Director of Operations also thanked Gill Walker, Matron Gynaecology who provided the support and leadership to the team over the period. He felt that all staff upheld the values of the Trust whilst working at a different hospital. The Director of Operations advised that the trust had received correspondence from Southport and Ormskirk thanking the team and Gill for the support and help for the hard work and dedication of the staff, explaining that the feedback from both patients and staff had been nothing but positive and they [the team] had been a pleasure to work with and a credit to the Trust.
061	**Apologies** – as above. **Declaration of Interests** – None **Welcome:** The Chair opened the meeting and welcomed members of the public to the meeting held in public.
062	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.

063 Patient Story

The Board receive a patient story from Tanya, who had used maternity services and neonatal services following the birth of twins. She provided the Board with a positive picture of the care she was given within the services and continued to be provided whilst the twins were on the neonatal unit. She explained that whilst the twins were on the neonatal unit she was staying in the residential facilities provided by the Trust. In response to a question on any problems she wanted to highlight given she lived on the Isle of Man, she advised that she could not fault the care and support provided or the provision of residential facilities, however she explained that there was no washing facilities for clothes at the residence and for someone like herself who had no support on the mainland this would have been useful to have given her length of stay. She did advise that the staff had helped with her clothes washing needs although it would have been nice not to have to rely on them.

The Chair thanked Tanya for her story and noted the problem she had encountered which would be looked into.

064 Minutes of previous meeting held on Friday 2 February 2018

The minutes of the meeting held on 2 February 2018 were approved, subject to an amendment to agenda item 046 - Financial Report & Dashboard. The Director of Finance advised that the statement regarding activity for maternity balancing out was incorrect and should be amended as activity for the year would not balance out. The Trust Secretary was asked to make the necessary amendment.

065 Matters arising and action log.

The Board noted that all actions had either been completed, were on the agenda for the meeting or were for action at a future meeting.

066 Chair's Announcements

The Chair advised on the CQC well led inspection that had been undertaken at the end of February and the positive feedback the Trust had received. He thanked everyone across the Trust. The Chair also thanked the acting Director of Nursing and Midwifery for co-ordinating the inspection with the CQC.

The Chair reported on his shadowing session he undertook with Business Intelligence and IM&T team. He advised that there was a very positive feel and attitude within the areas and was assured that the projects being undertaken were being managed well.

The Board noted the Chair's verbal update.

067 Chief Executive's report

The Chief Executive referred to her report and advised on the executive teams focus on implementation and delivery of the EPR system, noting that the risk had been escalated to the BAF as discussed at the last Board meeting. She advised that there was significant focus on the Trust's state of readiness.

The Chief Executive echoed the comments of the Chair regarding the CQC Well Led inspection and proffered a massive well done to everyone at the Trust. She advised that there were a number of areas that had received positive special mention during the feedback session. The Chief Executive advised that the Trust would be receiving the draft report from CQC by 12 April and the final publish report would be available towards the end of April.

The Board noted the Report from the Chief Executive.

068 **Chair's Report from Finance, Performance and Business Development Committee (FPBD)**

Jo Moore, Chair of FPBD presented the Chairs Report of the FPBD covering the meeting held on 19 February 2018 and ran through the main items discussed and where assurance was obtained.

Jo Moore referred to the Month 10 2017/18 Operational Performance when the Committee was formally briefed on a cancer target reporting incident which had been reported through STEIS. The Committee had noted that a full SI review would be undertaken which would include an external independent investigating officer and an external cancer manager. Jo Moore advised that the meeting was held before the STEIS was called on RTT.

Jo Moore advised that the Trust would be drawing down distressed financing in month 12 of £1.5m taking the full drawdown for the year to £2m. This had been reported both at previous Committee meetings and at the Board.

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

069 **Chair's Report from Quality Committee**

Susan Milner, Chair of the Quality Committee highlighted the work of the Committee at its meeting on 19 February 2018.

Susan Milner referred the Board to the discussion regarding the content of the SEE Report and whether additional added value could be received following a review of what was reported. She explained that the review would look at triangulating the information to provide a comprehensive analysis across all areas of clinical governance and be able to articulate better lessons learned. The Head of Governance had been tasked to conduct the review with a draft report available to the Quality Committee at the May 2018 meeting. The Chief Executive supported the comments and advised that before the new SEE report was reviewed by the Quality Committee it should be reviewed by the Executive. The Acting Director of Nursing and Midwifery would co-ordinate this.

Action 069: Acting Director of Nursing and Midwifery to co-ordinate the review of the new SEE report by the executive Team before its presentation to the Quality Committee.

Susan Milner advised that, as with FPBD, the Committee had received a detailed briefing on the 62 day Cancer target and had also noted a planned SI review would be undertaken. The Committee had supported Trust action to contact patients under the duty of candour.

Susan Milner referred the Board to the review undertaken by the Committee on the Research and Innovation Strategy 2018-2023 and advised that it was before the Board for approval.

Referring to the matters to highlight to the Board, Susan Milner advised that the Committee had reviewed the draft BAF risk for EPR and felt that the risk fitted within the Trusts Strategic objective of delivery of safe services. She noted that the Board would be discussing the risk in a separate meeting.

Susan Miner reported that the content of future Board Committee Chairs reports would include a section on 'Learning identified at the meeting' so that such learning could be disseminated across the Trust in a more structured way.

The Chair thanked Susan Milner for her report which was noted; he asked that the Board turn their attention to the Research and Innovation Strategy included in the Report.

Research and Innovation Strategy 2018 -2023

The Medical Director presented the Research and Innovation Strategy 2018-2023 and sought the

Board views on the content. He advised that the Strategy had been developed following comments received from the teams within the Trust and taking into account the direction of travel of Liverpool Health Partners and the Universities within the City.

The Board discussed the Strategy and in particular a number of comments were made.

The Chief Executive was mindful that the Strategy needed to also apply to Nursing and Midwifery led research, recognising that this was not as prominent as it should be in the Strategy. She felt there needed to be an established leader to bring this on within Nursing and Midwifery. The Chief Executive advised that aligning with the Universities, in particular John Moores University and Edge Hill University would support the development of Nursing and Midwifery led research. The Director of Nursing and Midwifery advised that discussion were ongoing with John Moores and meeting had been arranged with Edge Hill and also the University of Central Lancashire.

David Astley asked what was being done to allow for the additional focus on research and innovation and asked whether for clinicians PA's provided for this. In response the Medical Director advised that he was looking at job plans so that they were more specific for focus on research. He advised that the theme he was aiming for was that research was everyone's job and that either allowing for 1 PA to support this or doing its as extra to business as usual and receive recognition through the clinical excellence awards was two possible ways of providing that additional focus. The Chief Executive felt that if a PA was provided for innovation and research then there had to be measures in place to show that there was added value to the services of that research; if this was not the case then it would be appropriate for the PA to be removed. Referring to page 18 of the Strategy and the comment relating to lack of corporate support, the Chief Executive asked that this paragraph was amended as this did not reflect the position.

The Chair asked whether the Trust was prepared to invest resources into the Strategy as some of the statements made were ambiguous. Referring to the job plans, the Chief Executive advised that this was a matter for the Medical Director to decide on how this could be managed. She recognised the benefit of providing for research and innovation in job plans as this would attract the best people to the Trust, however the Strategy needed to fit within the Trusts Financial and Operational Plan and with this regard the Trust could not sign up to any additional resource and there was no additional pot of money.

The Chair asked how the Board would know how the Trust was delivering against the Strategy. In response the Medical Director advised that future Annual Reports and work plans would include the detail on delivery; this would be reviewed by the Quality Committee and reported to the Board for assurance. Susan Milner supported the comment noting that there would be 6 monthly reviews at the Quality Committee and that she would report to the Board on delivery in her Chairs report to the Board.

The Board noted all the comments raised during the discussion and approved the Strategy subject to final sign off by the Quality Committee.

Action 069(ii): Medical Director to present to the Quality Committee the final version of the Research and Innovation Strategy for formal sign off.

070 Serious Incident Report Q3

The Medical Director presented the Q3 Serious Incident Report.

The Medical Director advised that generally the overall the number of serious incidents were spread across the specialities. He advised that the Trust needed to do more to make sure lessons learned were shared. The acting Director of Nursing supported the comment and advised that steps were being taken at every opportunity to make sure learning was shared and that her team was leading the

way in making this happen more effectively. The Chief Executive felt that it would be appropriate to have a Board session on lessons learned and in particular how these were disseminated across the Trust. The Director of Workforce and Marketing advised that there was a good reporting culture in the Trust however the recent staff survey had identified a difference of view that staff were not as comfortable as they had been in sharing and raising concerns and this needed further investigation. The Director of Workforce and Marketing felt that the Trust would benefit from a rapid improvement event focused around learning, citing Mersey Care who had recently undertaken such an event.

The Medical Director advised that as this was a Q3 report it did not include the recent SI reports relating to 62 day Cancer and RTT. He reminded the Board that they had been kept fully up to speed with the issues surrounding both serious incidents and that both were being fully investigated.

The Chair thanked the Medical Director for his report which was noted.

071 Safer Nurse/Midwife Staffing Monthly Report Period 10

The Acting Director of Nursing and Midwifery presented the Month 10 Safe Staffing report and advised that the data presented in the report demonstrated the effective use of current Nursing & Midwifery resources for all inpatient clinical areas. She advised that there were only two red flag incidents reported.

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

072 Performance Report Period 10 2017/18

The Director of Operations presented the Performance Report for period 10 2017/18 and reported that the Trust was continuing to deliver the national targets to date with the exception of RTT 18 weeks and 62 day cancer.

The Director of Operations advised that both 62 day cancer and RTT incidents had been placed on the Strategic Executive Information System (STEIS) as serious incidents. Referring to 62 day cancer, the Director of Operations advised that delays in the pathway had not resulted in any harm to patients; however for additional assurance a multi-disciplinary team would also be reviewing each case and advised that the Trust had taken the decision to apply the duty of candour and had informed patients of the incident as reported earlier in the meeting. With regards to RTT, the Director of Operations advised that more work was needed to be done although there was some recognition that no harm had been caused to patients on the pathway. He advised that before applying the duty of candour the Trust needed to review further the cases in order to assess if any actual harm had been caused by the delays.

The Chief Executive advised that both Liverpool CCG and NHS Improvement had been kept fully informed on each incident and recognised that the Trust was, as a priority, looking at whether any harm had been caused to patients. The Chief Executive advised that in both the 62 day cancer incident and the RTT incident it was the right thing to do to apply the duty of candour even though this may not have been required.

Referring to the system failures that had resulted in the two incidents, the Director of Operations advised that NHSI had been kept up to date with developments and had commented that the Trust could not have done more following identification of the errors. The Chief Executive advised that there was no indication that anyone in the Trust had deliberately done anything wrong; however it was clear that errors had been made very early on the referral process. She advised that a full investigation was ongoing which would be reviewed by an SI Panel, the findings of which would be made available to the Board and would include lessons learned.

The Director of Operations ran through the remainder of the report and referred in particular the

levels of sickness for January which had seen an increase overall from 4.3% in December to 5.6% in January. In terms of diagnoses, cold/cough/flu were the most common diagnosis, followed by anxiety/stress/depression and then gastrointestinal problems.

The Chair thanked the Board for the candid discussion on 62 day cancer and RTT indicators and noted that for January 2018, the Trust had not submitted its 62 day cancer and RTT data to NHSI, as agreed with NHSI. He therefore felt that the Board could only accept and receive the performance report relating to all other performance measures with exception of 62 Day cancer and RTT.

The Board noted the Performance Report for period 10 2017/18 report, recognising the data included in the report for RTT and cancer was not correct.

073 Financial Report & Dashboard Period 10 2017/18

The Director of Finance presented the Finance Report and financial dashboard for month 10, 2017/18 and reported that at Month 10 the Trust was £0.088m favourable against the planned £3.438m deficit, and was forecasting delivery of the full year control total following receipt of the £3.2m STF.

The Director of Finance reported that the Trust was on target to deliver the full CIP for 2017/18. Referring to the BAF risks there had been no changes made to the risk score however following a review of the narrative a number of changes were made and reported to FPBD.

The Chair thanked the Director of Finance for presenting the Financial Report & Dashboard Period 10 2017/18 which was noted.

074 Fit for Future Generations Update

The Chief Executive provided a verbal update on future generations and advised that very little had changed since her last report. The Trust was continuing to respond to questions raised by NHSE in a timely manner and it was still hoped that the CCG would be able to go out to public consultation immediately after the local elections due to be held in May 2018.

The Board noted the position.

075 Review of risk impacts of items discussed

The Board noted the risks had been discussed during the meeting including:

- New BAF risk for EPR
- Learning from Incidents still not embedded
- Research and Innovation Strategy requires further review by the Quality Committee
- SEE Report that goes to the Quality Committee to be reviewed by the Executive before taking to Quality Committee.
- RTT and Cancer 62 day risks to delivery of targets and associated data quality risks.

076 Any other business & Review of meeting

The Board noted the transparent, frank and challenging discussion on items presented.

Date of next meeting

The Chair reported that the next meeting of the Board in public would be 6 April 2018

Agenda Item 2018/093

Liverpool Women's NHS Foundation Trust

TRUST BOARD
6 April 2018 Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
3 Nov 2017	2017/298	The Associate Medical Director to provide the Board with a demonstration of the mortality audit toolkit at a future Board meeting.	The Associate Medical Director	~~2 February 2018~~ 4 May 2018	A demonstration of the toolkit will be provided on 2 February 2018 Board meeting to coincide with the Q3 Mortality Report. Board workshop itinerary 2 February 2018. *The Board extended the presentation of the toolkit to a later date to allow for bedding in of the process.*
1 Dec 2017	2017/328	The Acting Director of Nursing and Midwifery to provide an update on the implementation of the National Maternity Review and Community Midwives Re-design at the Board meeting on 1 June 2018	Acting Director of Nursing	1 June 2018	To be reported at the 1 June 2018 meeting. Action ongoing
12 Jan 2018	2018/014	The Board Committees to review the BAF risks allocated to them to make sure that the content is updated	Board Committee's/ Acting Director of Nursing and Midwifery	31 March 2018 Complete	The BAF has been reviewed in full and amendments made to take account of target dates for action etc.
2 March 2018	2018/069	Acting Director of Nursing and Midwifery to co-ordinate the review of the new SEE report by the executive Team before its presentation to the Quality Committee	Acting Director of Nursing and Midwifery	30 April 2018	Executive and Quality Committee action
2 March 2018	2018/069(ii)	Medical Director to present to the Quality Committee the final version of the Research and Innovation Strategy for formal sign off.	Medical Director	23 April 2018 Quality Committee	Executive and Quality Committee action

	Completed actions: concluded before the next board or on the agenda of the next Board
	In Progress - either at Committee stage or awaiting presentation at Board or Board workshop
	in progress - missed original deadlines agreed at Board

Agenda Item	2018/095

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Chief Executive Report**
DATE OF MEETING:	Friday, 06 April 2018
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 ☒ **2.** CARING ☒ **3.** RESPONSIVE ☒ **4.** EFFECTIVE ☒ ***5.*** WELL LED ☒
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: **36T**
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***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable Or type here if not on list: 36T
	Date of meeting	36T

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

Gender Pay Report: The Trust Gender Pay Report will be published on the Trust web site from 30 March 2018. The Trust's people and audit Committees will be reviewing the content and any required actions.

Annmaria Ellard: Annmaria won the Lansinoh Healthcare Hero award in the Tommy's Charity awards in March 2018. Congratulations to Annmaria.

2018 Dedicated to Excellence Awards: A reminder that the awards will take place on Friday 20th April 2018 with 10 categories this year that includes two new categories: Dedicated to Clinical Audit; and Staff Fundraiser of the Year.

Rebecca Slater: Rebecca was awarded the Downtown in Business Apprentice of the Year in March 2018. Congratulations to Rebecca.

The North West Coast Genomic Healthcare Alliance Education Group - winners of the Transformation Award at the NWC CRN Research Awards in March 2018. https://www.liverpoolwomens.nhs.uk/news/award-recognises-ground-breaking-liverpool-work-to-help-women-with-the-angelina-jolie-gene/. Congratulations to the team

SECTION B – LOCAL

Local A+E Delivery Boards (North) Newsletter -Issue 9 (Attachment 1)

Cheshire & Merseyside Women's and Children's Services Partnership Vanguard Public survey (Attachment 2) –
The partnership has asked that the attached is circulated to encourage completion of the Cheshire & Merseyside Women's and Children's Services Partnership Vanguard Public survey.

Retirement of Derek Cartwright, Chief Executive of North West Ambulance Service (Attachment 4) – Derek Cartwright is to retire from North West Ambulance Service after more than 30 Years in the ambulance service on 1 June 2018.

Establishment of the Edge Hill University Medical School (Attachment 3): Edge Hill University has received validation from the GMC for the establishment of the Edge Hill University Medical School. The first intake for the new school will be in September 2020

SECTION C - NATIONAL

Governments Mandate to NHS England and Remit to NHS Improvement 2018-19 NHS mandate (attachment 5) – The Government has published the Mandate to NHS England setting out the key deliverables and goals for NHS England and NHS Improvement.

Closer working between NHS Improvement and NHS England (Attachment 6) - NHS England's board has proposed to increase joint working with NHS Improvement as both organisations look to speak with a single national voice and remove duplication. Closer working between NHSI and NHSE would enable system collaboration. The detail of how joint regional posts work in practice will be key. It will be important for there to be clear lines of accountability between the regional directors and the national bodies so that any conflicts of interest are managed appropriately.

CQC fees scheme 2018/19 **(Attachment 7)** - Care Quality Commission (CQC) has published its fees scheme for 2018/19, which sets out the changes to its fees structure following a consultation earlier this year

Board of Directors

Committee Chair's report of Quality Committee meeting held
19 March 2018

1. Was the quorate met? Yes

2. Agenda items covered

- **Subcommittee Chairs reports:** The Committee considered the sub-committee chair's reports.
- **Quality and Regulatory Improvement Requirements:** The Committee noted that the Care Quality Commission (CQC) draft report was expected on 12 April 2018 for comment on accuracy with the Final Report published at the end of April 2018.
- **Quarterly review of progress against Equality and Human Rights Goals 1&2 Quarter 3 2017/18:** The Committee noted that currently the Trust in performing an initial self-assessment against the grading standards the Trust Graded itself as 'Achieving' for 12 out of the 18 EDS2 outcomes, and 'Developing' for the remaining 6 outcomes. The Committee did not feel it had the assurance it needed from the report and asked that the Experience Senate undertake a review of the findings and provide a further update to the Committee for assurance.
- **Quality Performance Dashboard Report – Month 11:** The Committee received Month 11 2017/18 performance dashboard and was briefed on the actions being taken to address the two SIs relating to 62 day cancer and RTT. A full SI review was being undertaken for both incidents and that action plans were being monitored through FPBD.
- **Clinical Audit Programme:** The Committee reviewed the clinical audit work plan for 2018/19 and noted that each audit is risk assessed so that a priority level can be set for each. The Committee noted that the Effectiveness Senate would be reviewing each Audit and that at the end of the year a Clinical Audit Annual Report will be provided to the Quality Committee for review.
- **Review of Risk Appetite Statement 2018/19:** The committee reviewed its part of the Risk Appetite Statement that related to three of the five strategic aims: Safe; Effective; and Experience. The Committee agreed that:
  - To deliver safe services – the risk appetite was ***low***
  - To participate in high quality research and to deliver the most effective outcomes – the risk appetite was ***moderate***
  - To deliver the best possible experience for patients and staff – the risk appetite was ***low***.
- **Review of Quality Committee Terms of Reference:** The Committee reviewed its terms of reference and work plan noting that they had only recently been reviewed in December 2017. The Committee noted that the review brought the terms of reference in line with other Board committees. Changes were made to the terms of reference and the committee recommended the changes to the Board for approval.
- **Corporate Risk Committee Terms of Reference:** The Committee reviewed the terms of reference of the subcommittee, the Corporate Risk Committee and approved changes to the membership and reporting requirements.

3. Board Assurance Framework (BAF) risks reviewed
   - The Committee reviewed the quality related BAF risks it is responsible for on behalf of the Board. There were no changes made to the BAF risks following review.

4. Escalation report to the Board on Quality Committee Performance Measures
   62 day cancer and RTT. This is already known to the Board.

5. Issues to highlight to Board

None

6. Action required by Board

Board is asked to approve the amended terms of reference of the Quality Committee.

Susan Milner
Chair of Quality Committee

Attached Amended Terms of Reference

QUALITY COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Quality Committee (QC) (the Committee).
Duties:	The Committee's responsibilities fall broadly into the following three areas: **Strategy and Performance** a) Oversee the development and implementation of the Quality Strategy with a clear focus on upholding the tenants of quality (Governance, safety, patient experience and clinical effectiveness). b) Ensure that the Quality Strategy and performance are consistent with the Trust's; Vision and strategic objectives and oversee any initiatives undertaken by the Trust that relates to the development and implementation of the Quality Strategy. c) Review trends in patient safety, experience and outcomes (effectiveness) to provide assurance to the Board on performance and commission 'deep dives' as appropriate. d) To receive assurance that action plans arising from in-patient, out-patient and other care related surveys are being undertaken and make recommendations to the Board as appropriate. e) Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery **Governance** f) Oversee the effectiveness of the clinical systems developed and implemented to ensure they maintain compliance with the Care Quality Commission's Fundamental Standards in relation to Quality, Safety, experience and effectiveness. g) Obtain assurance of the Trust's ongoing compliance with the Care Quality Commission registration. h) Oversee the review of the NHS Improvement Quality Governance Framework. i) Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that

		risks to the strategic objectives relating to quality are being managed and facilitate the completion of the Annual Governance Statement at year end.
	j)	Obtain assurance that the Trust is compliant with guidance from NICE (through receipt of an Annual Report) and other related bodies.
	k)	Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from NHSI, the Care Quality Commission, the Health and Safety Executive and other external assessors.
	l)	Receive the annual clinical audit programme and provide assurance to the Board that clinical audit supports the Trust to provide safe and clinically effective patient care and obtain assurance that there is delivery against agreed annual clinical audit programme.
	m)	Implement and monitor the process for the production of the Trust's year end Quality Report before it is presented to the Trust Audit Committee and Board for formal approval;
	n)	Undertake an annual review of the Quality and Risk Management Strategies to ensure that they reflect all required priorities;
	o)	To have oversight of the Committees performance measures to ensure they are appropriate and provide assurance of compliance and escalate exceptions to Trust Board.
	p)	To review the proposed internal audit plan for all functions areas within the Committees remit e.g. Clinical Audit, Safety, Experience and Effectiveness.
	r)	Review the Trust's Research and Development Strategy and Innovation Strategy prior to their recommendation it to the Board of Directors
	s)	Approving the terms of reference and memberships of its subordinate committees
	Overall	
	t)	To approve any matters that, due to time constraints, could not be approved by the Board within the scope of the Committees areas of responsibility.

approved

	u) Referring relevant matters for consideration to other Board Committees as appropriate. v) Considering relevant matters delegated or referred to it by the Board of Directors or referred by any of the Board Committees w) Escalating matters as appropriate to the Board of Directors. Assurances will be provided from internal and external sources and will be included in a work plan approved by the Committee at the commencement of each financial year.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • *Medical Director • *Director of Nursing and Midwifery • *Director of Finance • *Director of Workforce and Marketing • *Director of Operations • *Committee Chairs of the Safe, Experience and Effectiveness Senates • Deputy Director of Nursing and Midwifery • Head of Governance *or their nominated representative who will be sufficiently senior and have the authority to make decisions Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be three members including two Non-Executive Directors and one Executive Director (one of whom must be either the Medical Director or Director

approved

	of Nursing and Midwifery or their deputy). The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a. Members Members will be required to attend a minimum of 75% of all meetings. b. Officers The Trust Secretary shall normally attend meetings. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held monthly. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
Accountability and reporting arrangements:	The Quality Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance (see Appendix 1). Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year.

approved

	Trust standing orders and standing financial instructions apply to the operation of the Committee.
Reporting Committees/Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee (See appendix 2): • Safety Senate • Effectiveness Senate • Experience Senate • Corporate Risk Committee • Hospital Safeguarding Board
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by GACA	20 November 2017
Approved by Board of Directors:	1 December 2017
Review date:	April 2018
Document owner:	Colin Reid, Trust Secretary ,Email: colin.reid@lwh.nhs.uk Tel: 0151 702 4033

approved

Appendix 1

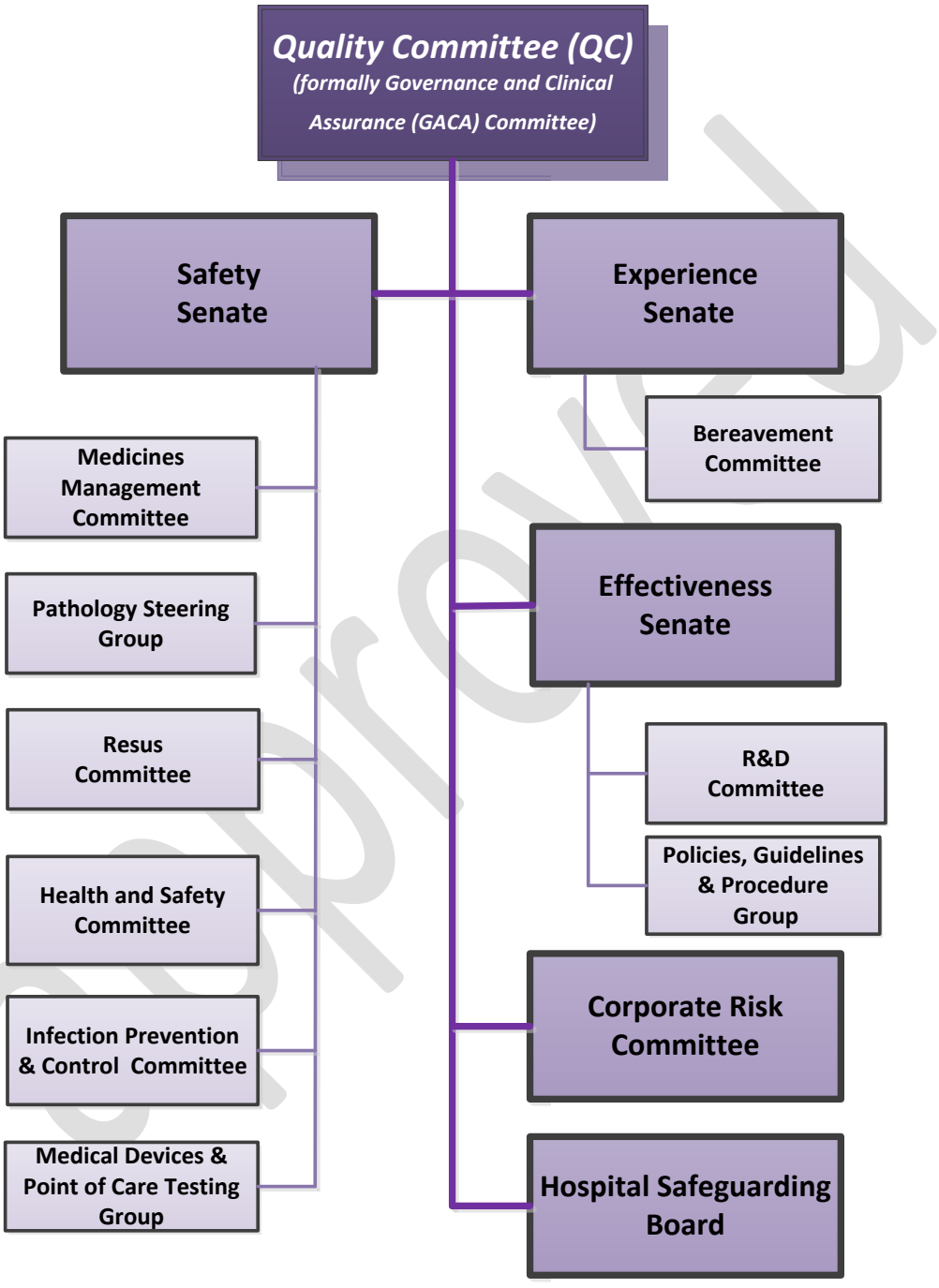
Board of Directors

Committee Chair's report of Quality Committee (QC) meeting held [ ]

1. Was the quorate met?
2. Agenda items covered
3. Board Assurance Framework (BAF) risks reviewed
4. Escalation report to the Board on QC Performance Measures
5. Issues to highlight to Board
6. Learning identified for dissemination within the Trust
7. Action required by Board

Chair of QC

Appendix 2



Approved

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 26 March 2018

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

2. **Agenda items covered**
   - **Month 11 2017/18 Operational Performance:** The Committee received Month 11 performance dashboard.
   - **Cancer target SUI Review Update:** The Committee received a detailed presentation update with regards to the recent cancer target and referral to treatment (RTT) reporting incident. The Committee was advised of the current position, changes to the management team structure, the planned trajectory to resolve the waiting targets and the recovery costs associated. The stated deadline to resolve both issues of July 2018 was noted. It was recommended that the national performance against RTT should be identified as priority to understand the Trust position against the national operational norm. It was agreed that this information would be helpful for the Board when considering the recovery trajectory set and the associated costs.
   - **Month 11 2017/18 Finance Performance Review:** The Committee received Month 11 2017/18 finance position, and noted an overall forecast deficit for the year of £3.4m. It was noted that the Trust had secured the block contract for 2018/19. The Committee requested a structured financial and performance review across the services where activity was below plan. The Executive Team would perform the review and advised that the high level information is included within the operational planning report.
   - **Operational Planning Update 2018/19:** As discussed at the last meeting and Trust Board the Committee was aware that the Trust has not signed up to the control total for 2018/19 as it is believed to be undeliverable. It was noted that the Trust Management Group had been informed of the circumstances which were based on the costs of the clinical case for change and supported the action taken by the Board of Directors. It was confirmed that the draft plan had been submitted to NHSI on 8 March 2018 and the final operational plan is due to be submitted on 30 April 2018.
   - **Strategic Outline Case updates:** The Committee noted further discussions with regulators to progress the SOC
   - **Cost Improvement Programme Update 2018/19:** The Committee received an update of progress against the 2018/19 CIP schemes which are being managed via the Turnaround and Transformation Committee. The Committee noted the CNST incentive scheme which if achieved expenditure would be returned to the Trust as a refund payment.
   - **Electronic Patient Record (EPR) Update and review of infrastructure in relation to IT Resilience:** Timescales remain the same for deployment for the Liverpool Women's NHS Foundation Trust as October 2018. It was confirmed that the Executive Committee receive a fortnightly update from the Chief Information Officer to monitor the risks associated.
   - **Update of GDE Fast Follower funding and expenditure:** The Committee received the detailed investment requirements against the GDE funding agreement and noted the procurement of IT solutions towards deployment of the GDE programme.
   - **Neonatal Capital Build Award:** The Committee received a progress update noting a programme launch meeting held on 9 March 2018. The Committee considered that suitable amounts of contingency should be built into the costings of project to ensure delivery within plan. It was confirmed that the Director of Operations would Chair the Project Board to deliver the programme.

NHS

- ~ **Liverpool Women's Health Consultancy Business Development Update:** The Committee received an update of consultancy activities and collaborative discussions. It was noted that negotiations are progressing with Qatar, China and India.
- ~ **Annual Review of Risk Appetite Statement 2018/19:** The Committee considered the Risk Appetite Statement and recommended that the risk appetite against its key strategic aim, 'to be ambitious and efficient and make the best use of available resources', should remain as a moderate risk appetite.
- ~ **Review of FPBD Terms of Reference and Business Cycle:** The Committee reviewed and approved the terms of reference and the business cycle for 2018/19.
- ~ **Sub Committee Chairs reports received**
  - o Turnaround and Transformation Committee held 5 March 2018
  - o Emergency Planning Resilience and Response Committee held 5 March 2018
  - o Information Governance Committee held 23 February 2018
  - o Digital Hospital Sub-Committee held 12 March 2018

3. Board Assurance Framework (BAF) risks reviewed

- ~ Board Assurance Framework (BAF): The Committee reviewed the financial related BAF risks it is responsible for on behalf of the Board. No changes were proposed.

4. Escalation report to the Board on FPBD Performance Measures

- ~ Cancer target reporting incident: Committee noted the detailed progress update and will continue to monitor progress. Further information was requested with regards to national RTT performance to benchmark against. The SUI review remains to be undertaken and the findings will be shared with the Board.

5. Issues to highlight to Board

- ~ None.

6. Action required by Board

- ~ Approval of Finance, Performance & Business Development Committee terms of reference (enclosed).

Jo Moore
Chair of FPBD

FINANCE, PERFORMANCE AND BUSINESS DEVELOPMENT COMMITTEE TERMS OF REFERENCE

Constitution:	The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Performance and Business Development Committee (the Committee).
Duties:	The Committee will operate under the broad aims of reviewing financial and operational planning, performance and business development. The Committee's responsibilities fall broadly into the following two areas: **Finance and performance** The Committee will: a. Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board. b. Review progress against key financial and performance targets c. Review on behalf of the Board, financial submissions or others, as agreed by the Board, to NHS Improvement for consistency on financial data provided. d. Review the service line reports for the Trust and advise on service improvements e. Provide oversight of the cost improvement programme f. Oversee external financing & distressed financing requirements g. Oversee the development and implementation of the information management and technology strategy h. Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework **Business planning and development** The Committee will: i. Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management j. Advise the Board and maintain an oversight on all major investments, disposals and business developments.

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	k. Advise the Board on all proposals for major capital expenditure over £500,000 l. Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • Chief Executive • Director of Finance • Director of Operations Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	The quorum for the transaction of business shall be three members including at least two Non-Executive Directors (one of whom must be the Chair or Vice Chair of the Committee), and one Executive Director. The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a. Members Members will be required to attend a minimum of 50% of all

	meetings. b. Officers Ordinarily the Deputy Director of Finance will attend all meetings. Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.
Frequency:	Meetings shall be held at least 5 times per year. Additional meetings may be arranged if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
Accountability and reporting arrangements:	The Finance, Performance and Business Development Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance (see Appendix 1). Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Finance, Performance and Business Development Committee.

Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Information Governance Committee • Turnaround and Transformation Committee • Emergency Planning Resilience & Response Committee • Digital Hospital Sub-Committee
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Finance, Performance & Business Development Committee:	26 March 2018
Approved by Board of Directors:	[6 April 2018]
Review date:	March 2019
Document owner:	Colin Reid, Trust Secretary Tel: 0151 702 4033

Appendix 1

Board of Directors

Chair's report of [Committee name] meeting held [Date]

1. Was the quorate met? Yes/No
   If No why not.
   Any actions taken.

2. Agenda items covered [including brief description arising from discussion]

3. Escalation report on Performance Measures discussed

4. New risks identified/action taken/escalation to BAF

5. Learning identified for dissemination within the Trust

6. Matters to be highlighted to the Board

7. Action required by the Board

[Name]
Chair of [Committee name]
Date

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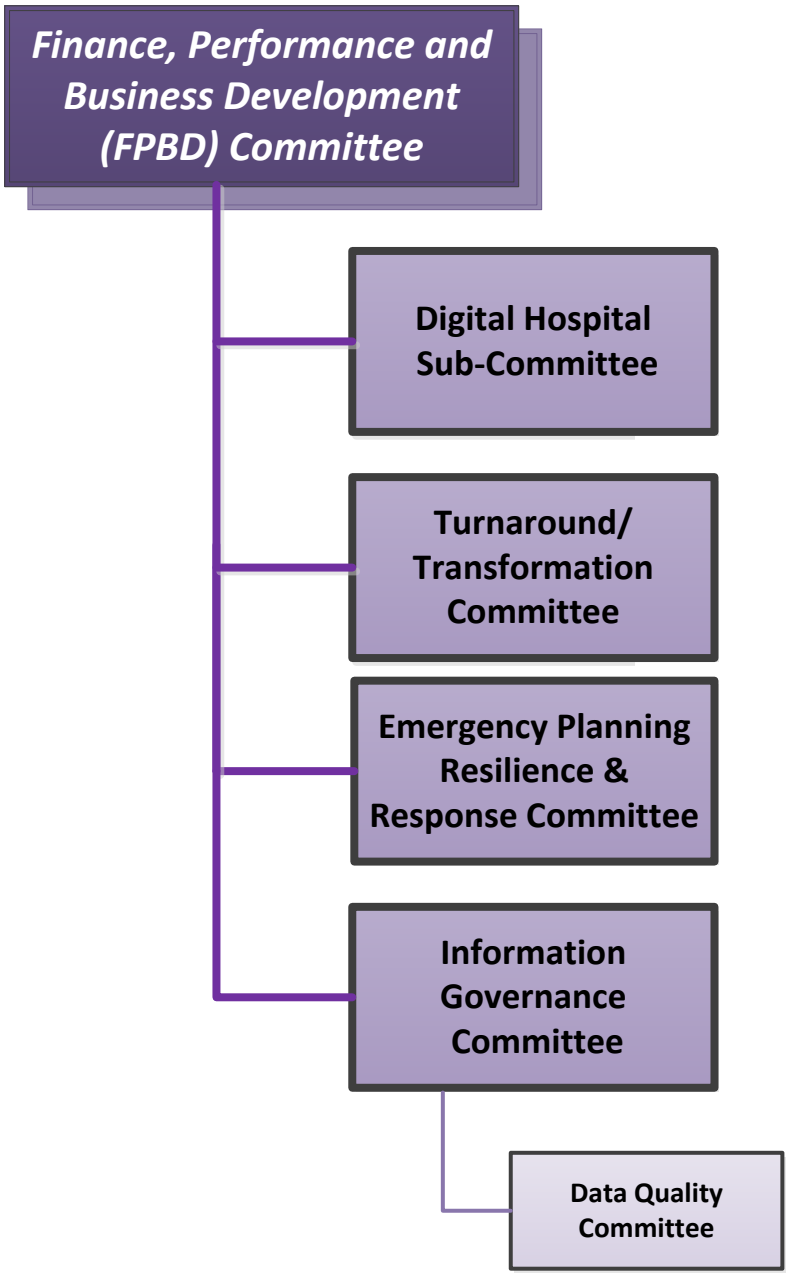
Finance, Performance and Business Development (FPBD) Committee
Digital Hospital Sub-Committee
Turnaround/ Transformation Committee
Emergency Planning Resilience & Response Committee
Information Governance Committee
Data Quality Committee

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Audit Committee meeting held 26 March 2018

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

2. **Agenda items covered**

- ~ **Follow up of Internal Audit and External Audit Recommendations**: The Committee received an updated position on outstanding recommendations but not yet due from 2017/18. It was noted that all recommendations from 2016/17 had been implemented and closed.
- ~ **Internal Audit Agency Progress Reports**: The Committee received two finalised audit reports and recommendations. It was noted that the Board Assurance Framework review received a meets requirement assurance level and the Information Governance review received a significant assurance level. There was a discussion about the audit plan review date for cyber security in light of system changes due to be implemented and best value. The Committee was comfortable with the reasons to change and agreed for the IM&T team to escalate to the Executive Team for appropriate approval and request a change to the audit plan formally. The Board would continue to receive assurance regarding IM&T matters through the Finance, Performance and Business Development Committee.
- ~ **Draft Director of Internal Audit Opinion and Annual Report 2017/18:** The Committee noted the draft internal audit opinion and annual report ahead of the final report to be received in May 2018. The Audit Manager reported a positive position. The Non-Executives recognised the excellent outcome achieved and acknowledged the work undertaken to attain this position by the finance team.
- ~ **Counter Fraud Progress Report and Draft Annual Report 2017/18**: The Committee received a progress report noting that the plan is on track for delivery by year end.
  The Committee also received the Draft Annual Report 2017/18. It was noted that the Trust had self assessed as amber rating against the NHSCFA standards due to a high level of compliance with the exception of 'Hold to Account' owing to a lack of occasion to demonstrate compliance. The Committee was advised that it is a positive position that the Trust has not had any incidents of fraud to make a referral however this has meant that there is no evidence of Trust compliance against this standard and unfortunately there is no neutral position.
- ~ **External Audit Update and Technical Update**: The Committee received a progress update noting that two areas have been identified as significant value for money risks: Financial sustainability and CQC Inspection Response. It was noted that the external auditors would provide final conclusions within a year end report and provide an audit opinion in May 2018. There was a discussion about the potential impact of the recent breach against the 62 day cancer target and the referral to treatment target on the quality account and audit opinion. The External Auditor advised that the technical team would be reviewing the accuracy of figures throughout the year and confirmed that there would be some emphasis on data quality issues. The Committee would be kept informed of progress ahead of the sign-off meeting in May 2018.
- ~ **Areas of Judgement in the Annual Accounts:** The Committee noted the areas in the 2017/18 accounts requiring the judgement of management. The Committee approved the approach that the accounts should be prepared on a going concern basis and noted the areas of judgement.
- ~ **Losses and Special Payments:** The Committee considered the recommended bad debt write offs from the period 2014/15 to be actioned by end March 2018. It was assured by processes undertaken to recover debts prior to write off.
- ~ **Raising staff concerns arrangements:** The Committee received an annual update. It was noted that the Trust had received six formal anonymous whistleblowing concerns which had been investigated and no actions taken, and there had been two employment tribunal cases held. The

Committee was assured that appropriate policies are in place and that appropriate action is taken to address any concerns raised.

- ~ **Review of Audit Committee Terms of Reference and Business Cycle:** The Committee reviewed and approved the Audit Committee terms of reference and business cycle. The Terms of reference would be submitted to the Board of Directors for ratification.
- ~ **Private meeting between Audit Committee members (NEDS) and internal and external auditors held at the end of the meeting:** Both internal and external auditors confirmed that working relationships between them and the Finance team, and other Executive members, were excellent and that they were pleased with the access they had been given to the Executive team to get fully up to speed with the Trust.

3. Board Assurance Framework (BAF) risks reviewed

- ~ Board Assurance Framework (BAF): The Committee was assured of the processes in place to review the BAF, consistent with the outcome from the completed internal audit report received, item 17/18/75i.a.

4. Escalation report to the Board on Audit Performance Measures

- ~ None

5. Issues to highlight to Board

- ~ The Board is asked to note the potential impact from the recent breach identified against the 62 day cancer target and the referral to treatment target on the quality account and audit opinion.

6. Action required by Board

- ~ Approval of Audit Committee terms of reference (enclosed).

Ian Knight
Chair of Audit Committee

AUDIT COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.
Duties:	The Committee is responsible for: **a. Governance, risk management and internal control** The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievements of the Trust's objectives. It will provide an independent and objective view on internal control and probity. In addition, the committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance, reviewing significant financial reports and the judgements contained in them. In particular, the Committee will review the adequacy of: • All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance to external bodies), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board • The process of preparing the Trust's returns to NHS Improvement (which returns are approved by the Board's Finance and Performance Committee) • The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification • The Trust's standing orders, standing financial instructions and scheme of delegation • The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State directions and as required by the NHS Counter Fraud Security Management Service • The arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In so doing

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the Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

The Committee will undertake an annual training needs assessment for its own members.

b. Internal audit

The Committee will ensure that there is an effective internal audit function established by management that meets mandatory government and Public Sector Internal Auditing Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- Reviewing the internal audit programme, considering the major findings of internal audit investigations (and management's response), and ensuring coordination between internal and external auditors
- Ensuring that the internal audit function is adequately resources and has appropriate standing within the organisation
- Annual review of the effectiveness of internal audit.

c. External audit

The Committee shall review the independence, objectivity and work of the external auditor appointed by the Council of Governors and consider the implications and management's response to this work. This will be achieved by:

- Consideration of the appointment and performance of the external auditor, including making recommendations to the Council of Governors regarding the former
- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure coordination with internal auditors and

with other external auditors

- Discussion with the external auditors of their local evaluation of audit risks and assessment of Trust and associated impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any audit work performed outside the annual audit plan, together with the appropriate of management's response
- Recommending to the Council of Governors the engagement of the external auditor in respect of non-audit work, taking into account relevant ethical guidance regarding the provision of such services
- Annual review of the effectiveness of external audit.

d. Other assurance functions

The Committee will review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. These will include, but will not be limited to, reviews and reports by the Department of Health, arms length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Resolution [Litigation Authority], etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc) or the Local Counter Fraud Specialist.

In addition the Committee will review the work of other Committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality Committee, Finance and Performance Committee and Putting People First Committee, and include a review of an annual report of each of the Committees against their terms of reference. In reviewing the work of the Quality Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

The Committee will also review all suspensions of standing orders and variation or amendment to standing orders.

The Audit Committee will report to the Board and to the Council of Governors any matters in respect of which it considers action or improvement is needed.

e. Counter fraud

The Audit Committee will satisfy itself that the Trust has adequate arrangements in place for countering fraud and will approve the appointment of the Local Counter Fraud Specialist. The Committee will review the outcomes of counter fraud work.

f. Management

	The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements. g. Financial reporting The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The Audit Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. The Audit Committee will review the Trust's annual report and financial statements before submission to the Board, focusing particularly on: • The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee • Changes in, and compliance with, accounting policies and practices • Unadjusted mis-statements in the financial statements • Major judgemental areas, and • Significant adjustments resulting from the audit • Letter of representation • Qualitative aspects of financial reporting.
Membership:	The Committee membership will be appointed by the Board of Directors from amongst its Non-Executive members and will consist of not less than three members. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be two members.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.

Attendance:	a. Members Members will be required to attend a minimum of 75% of all meetings. b. Officers The Director of Finance, Deputy Director of Finance, Financial Controller and Deputy Director of Nursing & Midwifery shall normally attend meetings. At least once a year the Committee will meet privately with external and internal auditors. The Chief Executive and other executive directors will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are within the responsibility of that director. The Chief Executive will also be required to attend when the Audit Committee discusses the process for assurance that supports the Annual Governance Statement. The Trust Secretary will attend to provide appropriate support to the Chair and Committee members.
Frequency:	Meetings shall be held at least four times per year. The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Audit Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance (see Appendix 1). Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide commentary in support of the Annual Governance Statement, specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the

	integration of governance arrangements and the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts. In providing this commentary in support of the AGS the Committee will seek relevant assurance from the Chair of the Board's Quality Committee. Trust standing orders and standing financial instructions apply to the operation of the Audit Committee.
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Audit Committee:	26 March 2018
Approved by Board of Directors:	[6 April 2018]
Review date:	March 2019
Document owner:	Colin Reid, Trust Secretary Email: colin.reid@lwh.nhs.uk Tel: 0151 702 4033

Liverpool Women's NHS Foundation Trust

Agenda Item	2018/099

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Annual Staff Survey Results 2017**
DATE OF MEETING:	Friday, 06 April 2018
ACTION REQUIRED	**For Discussion**
EXECUTIVE DIRECTOR:	Michelle Turner, Director of Workforce and Marketing
AUTHOR(S):	Rachel London, Head of Operational HR
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	**1.** Trust Constitution ☐ **4.** NHS Constitution ☐ **2.** Operational Plan ☐ **5.** Equality and Diversity ☐ **6.** Other: Click here to enter text.

EXTERNAL REQUIREMENT	**3.** NHS Compliance ☐	
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 content and approve proposed actions.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable
	Date of meeting	

Executive Summary

The paper provides an overview of the Staff Survey results 2017 which were published in March 2018. It highlights that there have been no significant changes compared to the 2016 results, and importantly, the key 'Engagement' score has remained stable. It illustrates that further work is to be done around a number of key themes including involvement and communication, and programmes of work including the Leadership Programme need to continue. It provides information on a new staff engagement tool 'Go Engage' and outlines next steps and key actions to be taken in response to the survey.

Report

Introduction

The fifteenth NHS staff survey was carried out between October and November 2017, with the results published in March 2018. The NHS Staff Survey is the national tool to measure levels of engagement and wellbeing amongst NHS Staff.

Our response rate at 61% remained significantly higher than the national average of 44%. Overall, there have been minimal changes to the results compared with 2016. We did not deteriorate on any questions and made a statistically significant improvement on one question, 'the number of staff who would feel confident reporting unsafe practice'.

It should be noted that LWH is classed as an 'acute specialist Trust' and our scores in the Staff Survey are benchmarked against these Trusts. Metrics used in the Staff Survey are either a percentage, or a scale score between 1 and 5. Acute specialist organisations consistently demonstrate the highest levels of staff engagement in the NHS.

It is encouraging that despite ongoing financial efficiency targets, ongoing demand for our services and the potential for major organisational redesign, our overall Engagement Score has remained stable at 3.8. (out of 5) and a majority of staff would recommend Liverpool Women's as a place to work or receive treatment (3.8 out of 5)

National Context

The national staff survey picture showed a trend of overall decline in the NHS, as 11 key findings improved and 21 key findings declined. In comparison to the national picture, LWH's trend of stability and slight improvement can be viewed positively.

The national staff engagement score of 3.78 is comparable to the LWH score of 3.8.

Quality of appraisals was identified as a national area for improvement, with staff giving an average rating for quality of 3.11 (out of 5). At LWH the rating was 2.93 (out of 5.)

There has been a year on year decline in relation to organisations providing 'equal opportunities for career development' however this is an area where the Trust outperforms other NHS Specialist Trusts with 91% reporting they believe equal opportunities are offered.

Another area of national decline is the number of staff reporting incidents and near misses, whereas at LWH the number of incidents and near misses has reduced and there have been improvements in the number of staff reporting these incidents.

The number of staff reporting 'good communication between managers and staff' is historically very low across the NHS, this year the national score was 33.5% compared to 31% at LWH.

The NHS National Workforce Strategy was published in draft earlier this year and set out a number of key priorities for NHS Trusts which included:

- Increase workforce supply with a mixture of new roles and attracting experienced staff back into the workforce
- Focus on retaining staff by providing flexible working, reward packages, good rota management and commitment to health and wellbeing.
- Widen participation in the workforce
- Invest in leadership training, including for medical staff
- Ensure robust workforce planning at local and regional level.

These issues will be reflected in the revised Putting People First Strategy and the Trust's approach to the Staff Survey.

Local Context

As a Trust we are currently consulting with staff and stakeholders about what our 'people priorities' should be for the next 3 years, as the current iteration of the Putting People First Strategy comes to an end and we develop the strategy for 2018-2021.

Pressures around recruitment and retention in some senior leadership roles remain and we are reviewing our recruitment and retention strategy. The talent management framework and new development programmes such as the 'Aspirant Manger' programme target individuals with the potential for progression and provide them with the necessary training, mentoring and support.

Our performance on the question 'Organisation takes action on health and wellbeing' is not reflective of the focus we have placed on health and wellbeing in the last 12 months which has included a revamped H&WB committee, and a range of activities and events from fundraising cycle rides to yoga classes and pamper days. We have commissioned a new physiotherapy and employee counselling services with extended services and have trained over 40 'Mental Health First Aiders'. These activities should hopefully be reflected in more positive responses in the next survey.

Four Board Trust wide 'Listening Events' with a wide range of staff have now taken place during the year, with the most recent Listening Event focusing on the refresh of the People Strategy.

Staff Engagement Score Results compared to other Trusts

Compared to last year's results, we have moved slightly higher up the table, reflecting the fact that there is a national downward trend. Alderhey is one Trust who has experienced a significant increase in their engagement score and we will review any actions taken to identify areas of good practice we could adopt.

Walton Centre	4.0
Clatterbridge	4.0
Heart and Chest	4.01
St Helen's and Knowsley	3.96
Wigan, Wrightington and Leigh	3.95
Mid Cheshire NHS FT	3.85
Alderhey	3.83
Liverpool Women's NHS FT	**3.8**
Birmingham Women's	3.78
Countess of Chester	3.75
Wirral University NHS FT	3.75
Liverpool Community Health	3.74
Royal Liverpool and Broadgreen	3.74
Warrington and Halton	3.74
Aintree	3.72
Southport and Ormskirk	3.63

Trends by directorate and staff group

See Appendix 1 for full details for key questions.

The most insightful indicator of staff engagement as a single question is whether '*Staff would recommend the Trust as a place to work or have treatment*'. The score for the Trust is 3.83. The results for this question is ranked by staff group as follows

General management	4.12
Medical	4.05
Neonatal and Midwives	3.94
Corporate Services	3.93
AHPS	3.93
HCAS	3.8
Adult nurses	3.74
Scientific & technical	3.68
Admin	3.62
Maintenance	3.59

For the question of '*Staff would recommend the Trust as a place to work or have treatment*', the analysis ranked by Directorate is as follows

Trust Offices	4.31
Finance	4.17
Neonatal	4.16
Human Resources	4.10
Medical	4.03
Governance	3.98
Theatres	3.83
Operational Management	3.82
Maternity	3.80
Hewitt	3.78
Imaging	3.72
Genetics	3.66
Estates	3.52
Gynaecology	3.53
IT	3.46
Integrated Admin	3.38

The positive results for the neonatal department build on last year's results and reflect the revised leadership structure, career development opportunities, investment in staffing and improved communications.

Leadership changes in Governance and Theatres also appear to have been received positively.

There has been significant change in the gynaecology directorate over the last 12 months in terms of ward reconfiguration and leadership changes which may have influenced the views of staff on this question.

Following the last staff survey, the IT department put in place a number of changes to improve communication and management support. The ongoing issue with accommodation of this team has likely influenced the results and this is being reviewed.

The admin teams have been subject to a high level of organisational change over the last few years and consistently report more negative feedback in the staff survey. A review of support structures, objectives and opportunities for involvement and voice will be undertaken for this group.

Estates results show a similar position to last year, and again, reflect high levels of change in the department in terms of leadership and the service has been outsourced.

Focused efforts will be made in the areas where it has been identified staff feel less engaged, specifically to ensure that meaningful action plans are produced by departments and these areas will be prioritised for team development interventions in the next 12 months.

Key Results

The key results and themes from the 2017 staff survey are summarised below.

Appraisals and Development

In line with the themes in previous staff surveys, whilst the quantity of appraisals is high (91%) quality is perceived to be low (2.93 out of a maximum score of 5, compared to 2.92 in 2016). Significant work has been undertaken to improve the quality of PDR training, however it is clear that staff feel their experience could be better. PDRS are rated lowest in admin and estates teams. There is further work to be done across the Trust to ensure that individual and team objectives are robust and follow a 'golden thread' from Trust wide objectives.

Incident Reporting

The Trust performs well compared to other acute specialist trusts in relation to confidence in reporting unsafe clinical practice, with 94% of staff reporting them in the last month. In addition, fewer staff witness near misses or incidents at LWH. Improved communications about identifying incidents and never events is taking place, and is now a regular item on 'In the Loop'. In addition the Head of Governance now attends the daily 'huddle' to advise staff of any incidents that have taken place in the last 24 hours and identify trends and resolve issues quickly.

Equality and Diversity

The percentage of staff experiencing discrimination at work (7%) is lower than acute and specialist Trusts and 89% of staff believe the Trust offers equal opportunities for career progression or promotion. The requirements of the Equality and Diversity Agenda will expand in the next 12 months with the introduction of the Workforce Race Equality Scheme and Workforce Disability Equality Scheme and the Trust will be focused on identifying and expanding leadership and development opportunities for BME and disabled staff.

Health and Wellbeing

51% of staff have felt pressure to attend work in the last 3 months despite illness due to pressure from colleagues, manager or themselves, compared to an average of 50% in Specialist Trusts and 34% have felt ill with work related stress over the last 12 months. Operational management, admin and estates are the areas where staffs have stated they have felt the most stressed, this reflective of the demands and other workforce issues in these areas.

Day to day health and wellbeing of clinical staff is intrinsically linked to effective rostering and workforce management. It has been identified that there remains further work to be done to maximise the capabilities of e-roster and balance staff wellbeing and flexible working requests with service demands. Stress will be a particular focus for the Health and Wellbeing Committee who will action any additional measures to be taken.

Job satisfaction

There have been small improvements in all questions in this section, which includes recommending the organisation as a place to work, motivation at work, ability to contribute to improvements, effective team working, levels of responsibility and satisfaction with levels of responsibility and support. Medical and Neonatal staff report feeling the most motivated. Issues with job satisfaction are highlighted in the areas of admin and estates.

It is notable in the Genetics department that although their overall scores in this area are mixed, 81% of staff feel they can contribute to improvements at work which is the highest of all the clinical areas. This likely reflects the work of the department in regularly meeting with staff in relation to potential national changes in the genomics service.

Managers

31% of staff feel communication from senior management is effective compared to 35% in Acute Specialist Trusts. It is notable that the neonatal department was the highest scoring clinical department by some margin, illustrating that it is possible to achieve good communication even within a busy clinical area where staff work shifts. Trust wide visibility programmes continue such as walkabouts with the Staff Side Chair and Medical Director and these have been received positively.

Patient care and experience

The score for 'staff satisfaction with the quality of work and care they are able to deliver' is 3.96 out of a maximum of 5. Acute Specialist Trusts average score is 4.02. This score has remained consistently positive and is an indication that staff continue to deliver excellent care, as reflected in the recent CQC feedback.

Harassment and Bullying

The numbers of staff experiencing physical violence from patients is lower than acute and specialist Trusts at 3%, as is the percentage of staff experiencing physical violence from staff at 1%. More staff at LWH are also prepared to report incidents of violence or bullying. 23% of staff report having experienced bullying or harassment from other staff in the last 12 months, the same figure as in Acute Specialist Trusts. The areas reporting the highest levels of bullying from staff are maternity (33%) and pharmacy (35%). Work has been previously undertaken in both these areas around multi-disciplinary working (in maternity) and divisions within teams (pharmacy). It should be noted that the Trust has had only 5 bullying and harassment investigations over the last 12 months.

The 6 trained 'Dignity at Work' advisors continue to be promoted as they provide impartial support and guidance to staff experiencing difficulties in the workplace and a second Freedom to Speak up Guardian has been appointed.

<u>Issues for consideration</u>

Go Engage System

The Trust has purchased a new employee engagement survey tool to replace the 'PULSE' survey which has irreparable technical difficulties. Go Engage has been developed by an occupational psychologist based at Wigan Wrightington and Leigh NHS Foundation Trust. Based on existing research, they have identified the nine 'enablers of engagement which been shown to lead to staff demonstrating greater advocacy, persistence, adaptability and discretionary effort.

The system consists of:

1. An online survey tool
2. 'Go Engage Programme' - an engagement programme delivered to teams, which provides the skills to enhance team engagement and performance.

The online survey tool gives the ability for the Trust to survey all staff on a quarterly basis and focuses on questions related purely to staff engagement. It provides detailed reports and analysis by department and

staff group. The Go Engage Programme is designed to help teams become more effective and high performing. 2 or 3 members of a team would attend a programme to learn the tools if improved team performance including lean methodologies, coaching skills, resilience and mindfulness, team roles and responsibilities, project management and communications skills.

The online survey tool will be rolled out from May onwards. We plan to undertake 2-4 team development programmes per year and will use the results of the staff survey to identify the teams who would most benefit from the programme.

Action

Engagement in developing meaningful local action plans following the last staff survey was mixed. These action plans must be measured on a regular basis through the performance framework and managers held accountable for progress. As in previous years, all teams will receive a detailed breakdown of their results and support to identify focused areas for improvement. The rollout of Quality Improvement Training in the organisation is ongoing and this will aid managers' abilities to enact change.

Some of the actions below are for managers to undertake and will be developed into a Trust Wide Action Plan with timescales and accountabilities for monitoring via the Trust Management Group (TMG). Actions will also be reflected in the revised Putting People First Strategy

Investing in our leaders

- 50% of Band 7's have now attended Leadership Development Programme. The learning from the programme will continue to be embedded and further rolled out. Quality Improvement Training and Practical Management Skills including rota management have been integrated into the programme.
- Audit PDRS across the Trust, review objectives and provide support to managers in setting objectives. Instigate the use of team objectives across the Trust.
- Roll out the 'Aspirant Talent' programme to identify future Ward Manager / Matrons
- Audit quality of TNAs and ensure link with all PDRS

Effective communication and management support

- Improve the visibility of all managers from executives to middle managers. Ensure visibility is an objective for all managers
- Medical Director / Staff Side Chair walkabouts with executive team members in partnership with the staff side chair to continue.
- Ensure timely communication of Trust wide objectives and vision and ensure that organisational goals are aligned with the objectives of managers, teams and individuals to achieve shared accountability.
- Continue with the quarterly Listening Events and ensure that feedback is provided on a regular basis.
- Roll out of Go Engage team development programme

Reward and recognition

These actions reflect 2016 actions as further work needs to be undertaken to progress.

- Review our reward and recognition structures

- Ensure that compliments and positive feedback are reported formally in the same way as complaints
- Implement simple schemes such as 'thank you' postcards on every reception desk for patients / staff to write the name of someone who has delivered exemplary service.
- Investigate other ways to recognise teams such as the ward accreditation scheme.

Health and Wellbeing

- Re-invigorate the existing health and wellbeing group to implement the health and wellbeing action plan produced in 2016.
- Assess the success of resilience training and implement further measures around stress management.
- Develop individual 'support plans' addressing work challenges, physical and psychological health
- Promote and maximise use of staff support and counselling services provided by Merseycare.

Workforce Planning

- Through the Strategic Workforce Group, ensure a Trust wide, co-ordinated approach to workforce planning and the development of new roles to deliver a sustainable workforce supply.

Conclusion

The results of the staff survey demonstrate that whilst stability has been achieved, focus at all levels of the organisation is required to ensure that the issues identified are progressed in the next 12 months with the objective of further improving our staff engagement score.

Recommendations

The Board is asked to note the contents of this report and provide support for the actions proposed.

Appendix 1- Trends by Directorate

Employee Engagement Questions *		2017 Trust Score	Estates & Facilities	Finance	Genetics	Gynae	Hewitt	Human Resources	Imaging	Int. Admin	Integrated Governance	IT & Information	Maternity	Medical	Neonatal	Operational Support Services	Pharmacy	Surgical	Trust Offices
2a	I look forward to going to work *(reply often and always)*	54%	21%	63%	42%	49%	57%	64%	57%	26%	65%	27%	53%	81%	60%	55%	38%	61%	50%
2b	I am enthusiastic about my job *(reply often and always)*	75%	50%	63%	67%	76%	72%	86%	86%	46%	85%	41%	82%	94%	83%	64%	56%	78%	67%
2c	Time passes quickly when I am working *(reply often and always)*	78%	64%	77%	81%	71%	76%	89%	100%	71%	90%	43%	80%	87%	85%	82%	76%	70%	83%
4a	There are frequent opportunities for me to show initiative in my role *(reply agree and strongly agree)*	72%	36%	83%	75%	69%	56%	81%	54%	40%	85%	76%	73%	83%	78%	91%	59%	71%	75%
4b	I am able to make suggestions to improve the work of my team / department *(reply agree and strongly agree)*	74%	43%	87%	85%	69%	73%	89%	57%	58%	93%	78%	72%	94%	73%	82%	47%	69%	92%
4d	I am able to make improvements happen in my area of work *(reply agree and strongly agree)*	52%	21%	77%	73%	43%	50%	71%	29%	33%	88%	59%	44%	67%	47%	91%	29%	44%	58%
21a	Care of patients / service users is my organisation's top priority *(reply agree and strongly agree)*	77%	71%	90%	85%	63%	86%	79%	69%	58%	82%	57%	72%	77%	89%	82%	71%	85%	100%
21c	I would recommend my organisation as a place to work *(reply agree and strongly agree)*	60%	36%	77%	56%	46%	56%	89%	62%	32%	64%	27%	58%	87%	75%	64%	53%	61%	67%
21d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation *(reply agree and strongly agree)*	79%	79%	90%	75%	67%	81%	89%	77%	64%	95%	68%	77%	88%	87%	82%	65%	78%	100%

Appendix 2 Staff Survey Action Plan 2016

Outstanding actions will be incorporated into the 2017 Action Plan.

Issue Identified	Action Description	Operational Lead	RAG Status	Target Date (Completion Date)	Progress Update
Management and leadership:	Ensure manages have meaningful objectives for which they are held to account. Where possible identify team objectives	General Manager for 3 clinical areas and Corporate / Department Heads		May 2018	Audit to be carried out on a cross section of staff by Q1 18/19
	Ensure line managers all identify 3 areas for improvement following discussion with their teams as part of the local staff survey action plans.	Head of Operational HR		May 2017	Completed
	All line managers to attend the Leadership Programme (or part modules as identified in TNA)	DDONM / Head of L&D		March 2018	Letter sent to all Band 7 managers. Sign up continues and attendance increasing- 50% of managers have signed up so far
	Review 'key skills' training available to line managers on finance, staff management and rota management	HR Business Partner / OD Business Partner		October 2017	Pick and Mix workshops as part of leadership programme open for all to attend including rota management
	Develop bespoke succession planning package for Nursing and Midwifery aspirant department managers	DDONM		October 2017	Programme developed, advertised and first participants commenced in Quarter 4.
	Ensure managers have skills to use talent management framework via PDR training	OD Business Partner		October 2017	PDR training and webinar available to ensure managers and staff can use tool

Communication:	Introduce walkabouts with Executive Team and Staff Side Chair (monthly)	Head of Operational HR		From July 2017	Monthly walkabouts ongoing
	Increase Trust wide communication on strategic direction of the Trust	Executive Directors		From April 2017	Ongoing
	Implement Trust Wide Listening Event (s) including Quality Improvement Methodology Training to identify improvement priorities for next 12 months	Head of L&D		September 2017	Listening events programmes established. Quality Improvement training integrated into leadership programme.
	Undertake audit of local communications methods	HR Advisors		May 2018	To be completed in Q1 18/19
	Undertake review of staff noticeboards	HR Advisors		May 2018	To be completed in Q1 18/19
Values and Behaviours	Board Development Session on embedding values and behaviours	OD Business Partner		June 2017	2 Board Sessions completed
	Fully roll out values based recruitment	HR Advisor		June 2017	To be completed in Q1 18/19
Recognition and Reward	Conduct review of reward and recognition structures, local and Trust wide	Deputy Head of Comms and Head of Operational HR		May 2018	To be completed in Q1 18/19
	Review alternative ways to recognise teams and drive good practice such as the ward accreditation scheme	DDONM		November 2017	Implemented
	Consider implementation of new schemes such as thank you cards on wards	HR team		November 2017	Implemented in some areas, to be rolled out Trust wide.

	Consider extension of existing schemes- meet with new starters after 3 months but rebrand as 'afternoon tea' and collect structured feedback	HR Team		November 2017	To be implemented in Q1 18/19
Health and Wellbeing	Implement actions in existing health and wellbeing action plan and relaunch H&WB group	OD Business Partner / Occupational Health		May 2017	HWB Group now re-established. All actions complete for 2016
	Review provision for stress and resilience training	OD Business Partner / Occupational Health		May 2017	New SLA for OH commencing in Oct 2017. Mental Health First Aider Training rolled out in the Trust.
Incident Reporting	Review de-briefing structures	Head of Governance		July 2017	Completed by new Head of Governance.
	Review staff support structures such as psychological supervision	Head of Governance / HRBP			POPPY study implemented. Divisions surveyed as to what support they would require. Decisions to be made in discussion with new Head of Governance and DDONM

Agenda Item	**2018/100**

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**
DATE OF MEETING:	6 April 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Julie King, Acting Director of Nursing and Midwifery
AUTHOR(S):	Clare Fitzpatrick, Acting Deputy 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 REQUIREMENT	**1.** Trust Constitution	☐	**4.** NHS Constitution	☐
	2. Operational Plan	☐	**5.** Equality and Diversity	☐
	3. NHS Compliance	☒	***6.*** Other: **NHS England Compliance**	
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**		Not Applicable	
	Date of meeting			

Executive Summary

Data presented in this report demonstrates the effective use of current Nursing & Midwifery resources for all inpatient clinical areas. The monthly report identifies staffing fill rates to demonstrate nursing and midwifery and care support levels. Fill rates of 100% mean that all planned staff were on duty. Fill rates of greater than 100% represent increased staffing levels to meet unplanned demand to meet patient care needs.

Fill rates of less than 100% reflect unplanned sick leave, vacancy or when staff are moved to work in another clinical area of greater clinical needs, due to low occupancy rates on their own area, or where by demands are greater in another clinical area.

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

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.

The use of CHPPD as a benchmark within and against other organisations is still under development by NHS Improvement and subsequent reports will be amended accordingly, presently CHPPD is featured alongside fill rates for each ward and department. Work has been undertaken to include this metric in April board report including a peer review score for nursing and midwifery CHPPD rates.

Care hours per day remain at a sustained level indicating a consistent level of care nursing/midwifery resource to provide care to our patients. The staffing across the inpatient ward areas for February 2018 remained appropriate to deliver safe and effective high quality family centred patient care day and night.

Ward Staffing Levels – Nursing and Midwifery Report

1.0 Purpose

1.1 Introduction

This report provides a monthly summary of Safe Staffing on all inpatient wards across the Trust. It includes exception reports related to staffing levels, related staffing incidents and red flags which are triangulated with a range of quality indicators both nursing and midwifery.

2.0 Safer staffing exception report

The safe staffing exception report (appendix 1), provides the established versus actual fill rates on ward by ward basis. Fill rates are accompanied by supporting narrative by exception at ward level, and a number of related factors are displayed alongside fill rates to provide an overall picture of safe staffing.

- Sickness rate and vacancy rate are the two main factors affecting fill rates, a growing trend is maternity leave, especially within maternity division, and this is being closely monitored.
- The monthly audit of nursing indicators was suspended in September 2017 by the previous DON. The trust is currently developing a ward accreditation system which will support the collection of quality indicators alongside real time patient safety flags. It is envisaged that this work will be completed by summer 2018.
- Trust wide review of nursing flags and red indicators, and reporting mechanism.
- ACE incident submissions related to staffing and red flags, related to staffing are monitored daily to act as an early warning system and inform future staffing planning:
- Nurse sensitive indicators demonstrate outcome for patients measuring harm:
- Cases of Clostridium Difficile (CDT)
    - Pressure Ulcers grade 1&2/Grades 3&4
    - Falls resulting in harm / not resulting in physical harm
    - Medication errors resulting in harm/ not resulting in harm
    - Babies requiring thermos cooling resulting in an Each Baby counts report

The inpatient wards have been able to maintain fill rates during the month of February 2018; the average fill rate for registered staff was greater than 96.46% day time, 97.53% night time, the average fill rate non registered staff 94.54% day time, 89.3%% night time trust wide. Maternity division displayed the lowest fill rate due to a seasonal spike in short term sickness, coupled with long term sick and maternity leave, agreements in place to recruit to cover maternity leave. Recruitment is ongoing within maternity to address this shortfall – interviews being held on April 6th.

Safe staffing for each ward is assessed on a daily basis by the relevant Divisional Matrons, and, during the evenings and weekends the duty manager for each division, in combination with the on call senior manager has the responsibility for ensuring safe staffing of all ward areas across the Trust.

There have been 3 red flag incidents, reported under the nursing/midwifery red flag staffing criteria, one for maternity services in relation to a delay in transfer to theatre for a third degree tear repair, not a true nursing red flag as the staffing issue was theatre and medical staffing. 2 for neonatal for omissions of medications, all were managed appropriately and no harm to patients was noted.

Investigations into these concluded that staffing levels and skill mix were safe at the time and did not contribute directly to incidents. All incidents were reviewed within the recommended timeframes and action plans commenced if appropriate. Gynaecology reported a 0 return for the fourth month for red flag incidents discussions with the senior gynaecology team have been undertaken to ensure correct reporting is undertaken. Deputy Director of nursing and midwifery has led a focus group and work stream to develop red flag reporting including, definition, reporting and escalation. Results of this work will be displayed in Aprils board report.

3.0 Summary

During the month of February, the wards were considered safe with low levels of harm and positive patient experience across all inpatient areas indicating that safe staffing has been maintained. There has been a noted slight decrease in fill rate within inpatient maternity services, due to long term sickness, a spike in short term sickness, maternity leave and vacancy, recruitment within maternity is ongoing with interviews noted for April 6th to address vacancy and maternity leave cover.

Work will continue within gynaecology outpatients to review safe staffing and gynaecology outpatient nursing staffing modal, this is not required on a UNIFY return as it only applies to inpatient staffing. All professional heads of are required to fulfil their bi – annual staffing report, work is ongoing to be present to the board in May 2018.

4.0 Recommendations

The board is asked to receive the paper for information and discussion.

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 (%)
Feb-18	Gynaecology	100.0%	98.82%	100.00%	100.00%

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 (%)
Feb-18	Induction&Delivery Suites	79.6%	121.4%	82.4%	88.1%
	Maternity Base	80.8%	75.7%	86.7%	94.0%
	MLU & Jeffcoate	74.4%	100.0%	81.0%	78.6%
	Maternity Total	78.9%	90.2%	83.2%	89.3%

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 (%)
Feb-18	Neonatal Care	110.5%	94.6%	109.4%	78.6%

Agenda Item	2018/101

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Performance Dashboard Month 11 (February)**
DATE OF MEETING:	Friday, 06 April 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Jeff Johnston, Director of Operations
AUTHOR(S):	Jeff Johnston, Director of Operations
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☒ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☐	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: **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 to note the content of the report.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee Quality Committee
	Date of meeting	Monday, 26 March 2018 Monday, 19 March 2018

Report

1. Introduction

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

Performance Dashboard TB - Febru

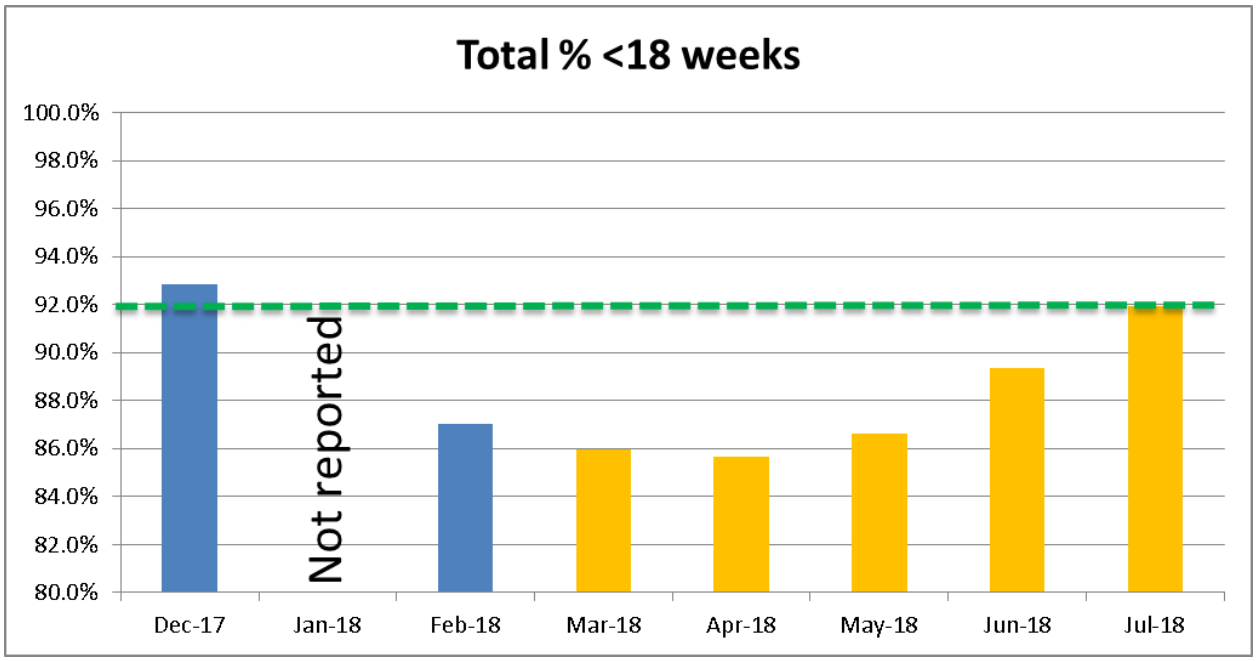
2.0 NHSI Targets – Access Targets including Cancer targets

2.1.1 18 weeks RTT and patients waiting greater than 52 weeks targets

The Trust reported a serious untoward incident in February with regard to the accuracy of reporting of the 18 week RTT target. The Trust has been unable to report an accurate position for January. The Trust has submitted an RTT submission for February of 87% which has been through a significant internal validation process (review of 7000 patient records) and officially signed off by the Director of Operations. To provide further assurance an external audit commenced on the 26th March, 2018 by a company specialising in access targets.

A full report and recovery plan was submitted and discussed at Finance Performance and Business Development Committee in March. In this report the recovery plan highlights a return to RTT compliance by July 2018. The Trust is expecting RTT performance to reduce slightly in March before an improving position in April. This is due to the majority of additional patient activity will take place in April, May and part of June.

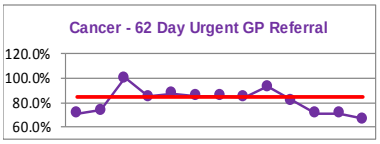
To add some context to this performance the national position for RTT reporting for gynaecology in January is 89.3 % and LWH gynaecology is 86.4% and the all speciality national performance is 88.2% and LWH is 87%.



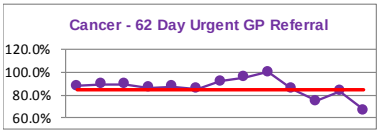
Within the validation the Trust has identified 15 patients with open pathways that have exceeded 52 week wait for treatment. The root cause analysis and harm review is in progress. This has also been reported as part of the RTT submission.

2.1.2 Cancer Target 62 days – GP referrals (before and after re allocation)

All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (Before re-allocation) Provisional Position	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Actual	71.4%	73.9%	100.0%	85.0%	87.5%	85.7%	85.7%	84.6%	93.3%	81.8%	71.4%	71.4%	66.7%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation) Provisional Position	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Actual	88.2%	89.5%	89.5%	86.4%	87.5%	85.7%	92.3%	95.7%	100.0%	85.7%	75.0%	83.3%	66.7%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



Further, to the SUI declared in February for the 62 day Cancer target reporting, systems and processes have been amended to ensure the data is accurate across all cancer targets. The information for January and February has been cleansed and reflects the true position for both GP referral and consultant upgrade. All other months are not accurate and no decision has been made by NHSE if they will require a retrospective correction.

In February, 3 complex patients exceeded the 62 day target, 2 of these patients were dated (within 62 days) to have procedures, however, due to cardiac conditions were declared not fit via anaesthetic review. This delayed their treatment date and therefore caused the breach of the target. One of these patients also exceeded 104 days to treatment (over 40 days to be fit for surgery) which requires our clinicians to undertake a harm review which will be completed week ending 23rd March, 2018.

The third patient was delayed due to failed ambulatory procedure converted to inpatient general anaesthetic. Subsequently, histopathology results were delayed which compounded the length of the overall breach. The Trust continues to activity monitor the histopathology performance and continues to raise concerns through quality meetings with the pathology provider.

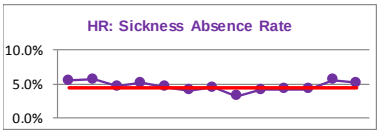
Breach analysis reports have been completed and will be validated in the quality meeting with the CCG. February was a very low month for diagnosed cancers with only 9 patients and hence impact on target with 3 complex patients in the cohort for this target. None of these patients were impacted by the SUI.

The Board should note that the Trust also failed in month for the 2 week wait (by 1 patient 0.3%) and the 31 day to Definitive Treatment Target (4 patients breached of which 2 are the same complex patients who breached the 62 day target).

3.0 Quality Schedule

3.1 Sickness

HR: Sickness Absence Rate	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Actual	5.6%	5.7%	4.6%	5.2%	4.6%	4.1%	4.5%	3.3%	4.2%	4.3%	4.3%	5.6%	5.2%
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%



Sickness increased in all of the three largest areas: Gynaecology, Maternity and Neonates are all in excess of 4.5% and have the largest proportion of staff.

Overall there was a slight increase in short term sickness absence. The proportion of overall sickness split by short term & long term changed from 39%/61% in month ten, to 48%/52%

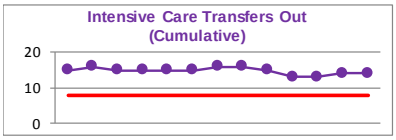
In terms of diagnoses, cold/cough/flu became the most common diagnosis, followed by anxiety/stress/depression and then gastrointestinal problems.

Managers continue to actively manage sickness to the Trust policy.

4.0 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 14 patients, the group consider the transfers to be appropriate.

Intensive Care Transfers Out (Cumulative)	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Actual	15	16	15	15	15	15	16	16	15	13	13	14	14
Target	8	8	8	8	8	8	8	8	8	8	8	8	8



The target is based upon previous year's 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.

5.0 Conclusion

There are concerns with regard to the Cancer targets and 18 weeks RRT which both form part of the serious untoward incident review. The Cancer targets data has been cleansed for January and February and are reported correctly, all other previous months are incorrect. The RTT data is now being reported at 87% and there is a

recovery plan to ensure compliance by July, 2018. This is significant progress in one month since the incident was declared.

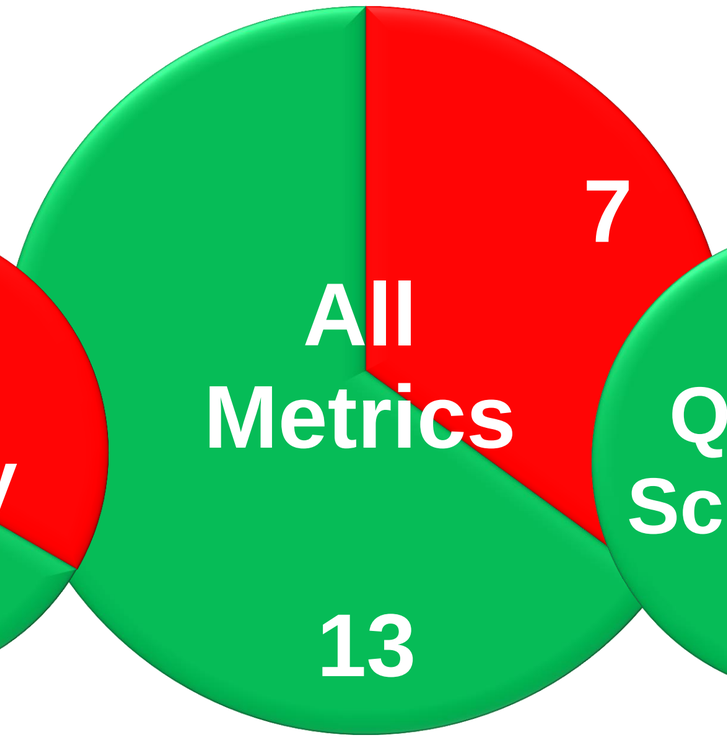
Unfortunately, there have been a number of extremely complex patients with co morbidities who have not been able to be treated within 62 days. These have contributed to the overall low performance against both the 62 day target and the 31 DDT target.

6.0 Recommendation

The Board note the content of the report.

Liverpool Women's NHS Foundation Trust

Performance Report for Trust Board — Month 11 - February 2018



* 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 11 - February 2018

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	Finance	3	3	3	3		3	3	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 (Number)	KPI104 (EAS5)	Infection Control	1	0	0	0		0	0	0		0	0	0		0	0		
Infection Control: Clostridium Difficile - infection rate (12-month rolling) 1 Qtr Behind	KPI320	Infection Control	Refer to Infection Control																
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate (12-month rolling) 1 Qtr Behind	KPI105 (EAS4)	Infection Control	Refer to Infection Control																
Meticillin-sensitive Staphylococcus aureus (MSSA) rates (12-month rolling) 1 Qtr Behind	KPI335	Infection Control	Refer to Infection Control																
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) rates (12-month rolling) 1 Qtr Behind	KPI336	Infection Control	Refer to Infection Control																
Never Events	KPI181	Head of Governance	0	1	0	0		0	0	0		1	0	0		0	0		
NHSE / NHSI Safety Alerts Outstanding	KPI193	Head of Governance	0	0	0	0		0	0	0		0	0	0		0	0		
Mortality Rates: Hospital Standardised Mortality Rates (HSMR) Gynaecology (1 Month Behind)	KPI321	Medical Director	Refer to qtrly Mortality report																
Mortality Rates: Summary Hospital Mortality Indicator (SHMI) (1 Month behind)	KPI322	Medical Director	Refer to qtrly Mortality report																

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	Human Resource	4.5%	4.64%	5.17%	4.56%		4.05%	4.51%	3.26%		4.15%	4.29%	4.28%		5.58%	5.23%		

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)	Operational Manager	92%	94.55%	95.31%	94.83%	94.90%	94.25%	93.67%	93.45%	93.78%	94.71%	93.64%	92.79%	93.76%		87.51%		
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (**Before re-allocation**) **Provisional Position**	KPI031 (EB12)	Cancer Lead	>= 85%	100.00%	85.00%	87.50%	91.38%	85.71%	85.71%	84.62%	85.19%	93.33%	81.82%	71.43%	81.03%	73.08%	66.67%		
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (**Before re-allocation**) **Final Reported Position**	KPI031 (EB12)	Cancer Lead	>= 85%	100.00%	85.00%	76.19%	85.45%	90.91%	95.83%	84.00%	90.14%	100.00%	86.36%	68.42%	82.00%	73.08%			
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (**After Re-allocation**) **Provisional Position**	KPI030 (EB12)	Cancer Lead	85%	89.47%	86.36%	87.50%	87.50%	85.71%	92.31%	95.65%	92.00%	100.00%	85.71%	75.00%	85.45%	76.92%	66.67%		
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (**After Re-allocation**) **Final Reported Position**	KPI030 (EB12)	Cancer Lead	85%	87.50%	85.00%	88.89%	87.04%	95.24%	*95.83%*	*95.45%*	95.52%	100.00%	90.48%	*72.22%*	85.42%	*76.92%*			
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Numbers (if > 5, the target applies)	KPI033 (EB13)	Cancer Lead	< 5	0.0	1.0	0.5	1.5	0.0	0.0	0.5	0.5	0.0	0.0	0.5	0.5	0.5	0.0		
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Percentage	KPI034 (EB14)	Cancer Lead	>= 90%	No Pts Applicable	100%	100%	100%	No Pts Applicable	No Pts Applicable	100%	100.00%	No Pts Applicable	No Pts Applicable	100%	100.00%	100%	No Pts Applicable		
Complaints: Number Received	KPI038	Ward Manager	<= 15	10	9	5		5	11	9		14	9	6		2	4		

Performance and Information Department
Performance Team

Liverpool Women's NHS Foundation Trust

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	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	HR	<= 4.5%	4.64%	5.17%	4.56%	4.05%	4.51%	3.26%	4.15%	4.29%	4.28%	5.58%	5.23%	

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	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)	Chris McGhee	0	0	0	0	0	0	0	0	0	0		15	
A&E: Total Time Spent in A&E 95th percentile	KPI012 (KPI_62)	Sharon Owens	<= 240	235	231	220	221	221	210	230	214	204	223	225	
Friends & Family Test (Upper quartile will recommend)	KPI089	Ward Manager	>= 75%	97.5%	98.5%	85.2%	96.7%	94.6%	97.2%	94.7%	97.6%	98.8%	99.0%	96.2%	

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		HR	<= 4.5%	4.64%	5.17%	4.56%	4.05%	4.51%	3.3%	4.15%	4.29%	4.3%	5.6%	5.2%	

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		Christopher Lube	0	1	0	0	0	0	0	1	0	0	0	0	
Mortality Rates: Summary Hospital Mortality Indicator (SHMI) (1 Month behind)	KPI322		Medical Director	Refer to qtrly Mortality report												

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		Debi Rice	<= 15	10	9	5	5	11	9	14	9	6	2	4	

LWH Trust Objectives 2017/18 Month 11 - February 2018

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	Jill Harrison	< 6.1%	0.14%	0.38%	0.28%	0.15%	0.28%	0.29%	0.31%	0.15%	0.16%	0.44%	0.33%	
Deaths (All Live Births within 28 Days) Booked births	KPI168	Jill Harrison	< 4.6%	0.15%	0.26%	0.29%	0.15%	0.28%	0.29%	0.16%	0.00%	0.16%	0.30%	0.34%	

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	Abraham Ssenoga	8 per year (Rolling year)	15	15	15	15	16	16	15	15	16	14	14	

Agenda Item	2018/102

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Month 11 Finance Report**
DATE OF MEETING:	Friday, 06 April 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	Janet Parker, Acting 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:	
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:-….)***	***Board is asked to note the Month 11 Financial Position***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance, Performance & Business Development Committee		
	Date of meeting	26 March 2018		

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 11 the Trust is £0.114m favourable against the planned £3.779m deficit.

As reported at Month 9 following a detailed review of the overall position, the Trust has been able to improve the forecast deficit to £3.7m on a non-recurrent basis. This will attract additional STF of £0.3m which brings the overall forecast deficit for the year to £3.4m.

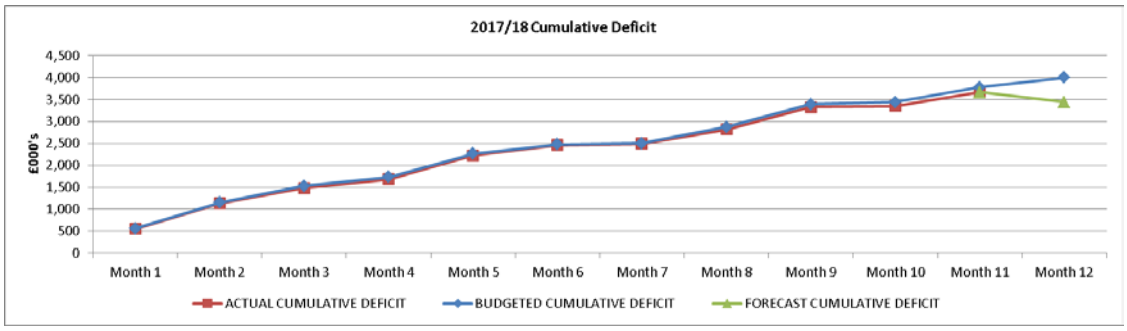
The Trust delivered a finance and use of resources' of 3 in month which is equivalent to plan.

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

Report

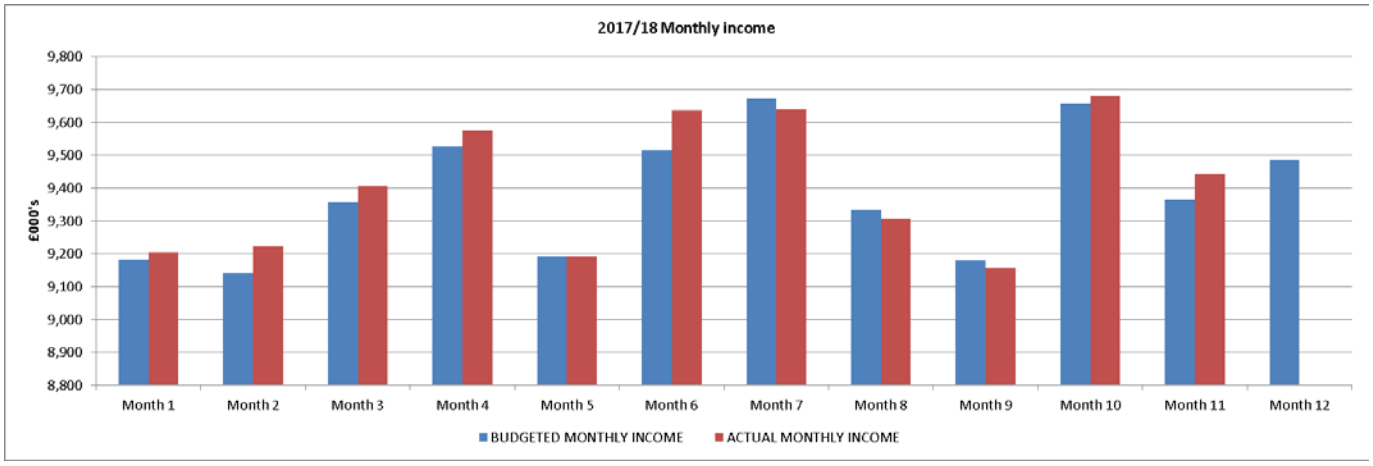
1. Month 11 2017/18 Summary Financial Position

The 2017/18 deficit is profiled below.



The Trust is achieving the planned deficit at Month 11 and is forecasting a £0.3m non-recurrent improvement at Month 12 (which will be matched by STF).

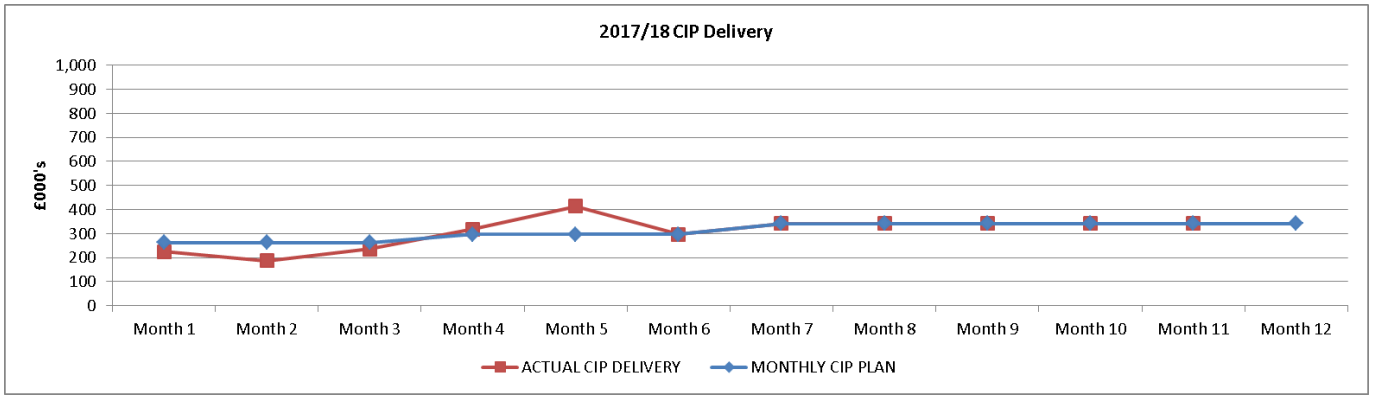
Despite a large proportion of income being under block contract with the Trust's main commissioners, there remains an element of payment by result (PbR) in the income plan. Within the financial plan the block is profiled to reflect expected activity levels in each month.



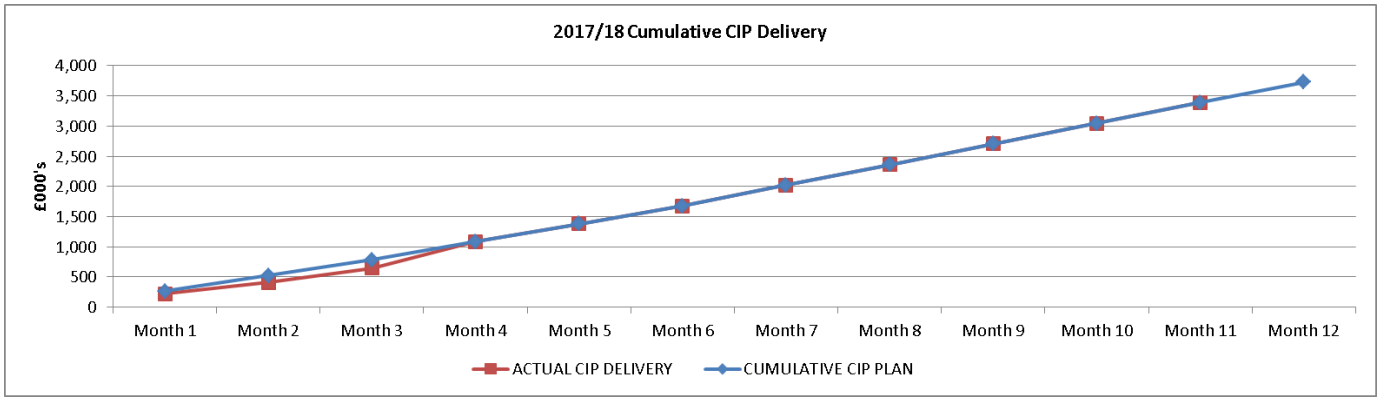
To date, the overall CCG block payment has been £3.3m higher than what would have been received under PbR for the level of activity during 2017/18. This has arisen particularly across both Gynaecology and Maternity, with activity levels in each currently below plan as previously reported. Despite a shortfall in activity, overall income remains ahead of plan due predominantly to neonatal revenue in year.

2. Month 11 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, with £0.2m of this remaining non-recurrent into 2018/19.



Actual CIP delivery is £0.333m in month which includes £0.055m of mitigations against the plan. Both in month and cumulatively the Trust is on plan overall.



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

3. Service summary overview

Both maternity and gynaecology are performing under block levels, which for these services cumulatively amounts to £2.9m YTD. It has been confirmed that this income will be covered by the Acting as One arrangement into 2018/19, however this poses a risk into 2019/20.

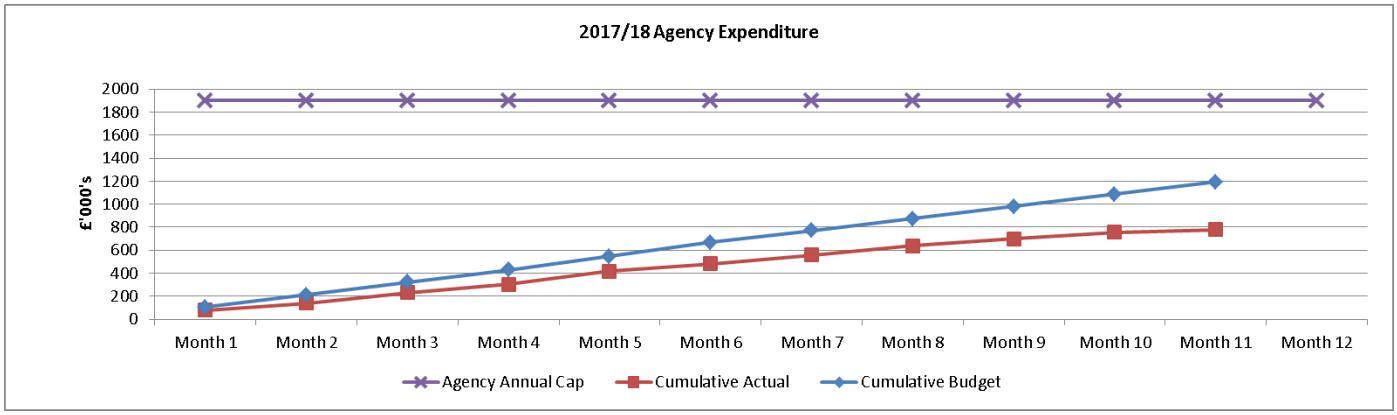
The maternity service is forecasting an underspend on pay given the current and further expected attrition of midwives in line with lower births. However, income is forecast to remain significantly down due to non-block underperformance.

The neonatal service continues to benefit from transport income over and above planned levels and from activity across the non-block elements of the contract. Out-performance is expected to continue until the end of the year resulting in a positive variance.

Hewitt Fertility Centre remains on target to deliver its current contribution target of £2.5m.

4. Agency Spend

The annual agency cap set by NHSI for the Trust is £1.9m. In Month 11 the Trust incurred £0.024m of agency expenditure (cumulative £0.778m) and plans to remain within the cap for the financial year.



5. Cash and borrowings

The Trust identified an operational cash borrowing requirement of £4.0m for 2017/18. This was on the basis of a planned closing cash balance of £1m at the end of 2016/17 as per DH distressed financing cash drawdown requirements.

However towards the end of 2016/17 the Trust was able to improve the deficit through non-recurrent improvement and additional STF funding. This led to an improvement in the closing I&E position of £2.3m and an improved 2017/18 brought forward cash balance.

This position has supported the Trust's 2017/18 in-year cash balances and as reported at Month 10 the Trust has drawn down £0.5m in Month 10. A submission was made to draw down the additional £1.5m in Month 12 taking the full drawdown for the year to £2m, as previously reported to Board.

6. BAF Risk

There are no proposed changes to the related BAF risk scores.

7. Conclusion & Recommendation

The Board are asked to note the Month 11 financial position.

Appendix 1 – Board pack

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M11

YEAR ENDING 31 MARCH 2018

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M11
YEAR ENDING 31 MARCH 2018

USE OF RESOURCES RISK RATING	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR Budget	YEAR FOT
CAPITAL SERVICING CAPACITY (CSC)				
(a) EBITDA + Interest Receivable	2,025	2,086	2,341	2,825
(b) PDC + Interest Payable + Loans Repaid	2,066	4,256	2,532	4,707
CSC Ratio = (a) / (b)	**0.98**	**0.49**	**0.92**	**0.60**
NHSI CSC SCORE	**4**	**4**	**4**	**4**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25				
LIQUIDITY				
(a) Cash for Liquidity Purposes	(2,100)	(5,942)	(2,598)	(4,636)
(b) Expenditure	101,106	101,395	110,277	110,524
(c) Daily Expenditure	303	304	302	303
Liquidity Ratio = (a) / (c)	**(6.9)**	**(19.6)**	**(8.6)**	**(15.3)**
NHSI LIQUIDITY SCORE	**2**	**4**	**3**	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)				
I&E MARGIN				
Deficit (Adjusted for donations and asset disposals)	3,779	3,662	3,998	3,440
Total Income	(103,122)	(103,462)	(112,608)	(113,326)
I&E Margin	**-3.66%**	**-3.54%**	**-3.55%**	**-3.04%**
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)		-3.54%		-3.04%
I&E Margin (Plan)		-3.66%		-3.55%
I&E Variance Margin	**0.00%**	**0.13%**	**0.00%**	**0.52%**
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	1,760	1,760	1,924	1,924
YTD Agency Expenditure	1,192	778	1,301	821
	-32.27%	**-55.80%**	**-32.38%**	**-57.33%**
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: M11
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	(8,416)	(8,438)	22	(95,174)	(95,291)	117	(103,786)	(103,790)	3
Non-Clinical Income	(950)	(1,005)	56	(7,948)	(8,171)	223	(8,822)	(9,536)	714
Total Income	**(9,365)**	**(9,443)**	**78**	**(103,122)**	**(103,462)**	**340**	**(112,608)**	**(113,326)**	**718**
Expenditure									
Pay Costs	5,609	5,578	31	61,924	61,876	48	67,503	67,439	64
Non-Pay Costs	2,261	2,318	(57)	24,764	25,102	(338)	27,046	27,357	(311)
CNST	1,311	1,311	(0)	14,417	14,417	0	15,728	15,728	0
Total Expenditure	**9,180**	**9,207**	**(27)**	**101,106**	**101,395**	**(290)**	**110,277**	**110,524**	**(247)**
EBITDA	**(185)**	**(236)**	**51**	**(2,016)**	**(2,067)**	**50**	**(2,331)**	**(2,802)**	**470**
Technical Items									
Depreciation	366	404	(38)	4,044	4,165	(121)	4,419	4,537	(117)
Interest Payable	36	19	17	396	238	158	432	260	172
Interest Receivable	(1)	(3)	2	(9)	(20)	10	(10)	(23)	13
PDC Dividend	124	130	(6)	1,364	1,350	14	1,488	1,473	15
Profit / Loss on Disposal	0	0	0	0	(1)	1	0	(1)	1
Total Technical Items	**525**	**551**	**(25)**	**5,795**	**5,731**	**64**	**6,329**	**6,245**	**85**
(Surplus) / Deficit	**341**	**315**	**26**	**3,779**	**3,665**	**114**	**3,998**	**3,443**	**555**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
EXPENDITURE: M11
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	341	362	(21)	3,744	3,896	(152)	4,085	4,253	(168)
Medical	1,253	1,275	(22)	13,687	13,788	(100)	14,928	15,057	(129)
Nursing & Midwifery	2,484	2,470	13	27,536	27,576	(40)	30,009	30,011	(2)
Healthcare Assistants	406	401	5	4,517	4,447	70	4,924	4,830	94
Other Clinical	538	565	(27)	5,925	5,897	27	6,454	6,492	(38)
Admin Support	140	142	(2)	1,539	1,711	(172)	1,679	1,862	(184)
Corporate Services	342	340	2	3,784	3,783	1	4,125	4,113	12
Agency & Locum	106	24	82	1,192	778	414	1,299	821	479
Total Pay Costs	**5,609**	**5,578**	**31**	**61,924**	**61,876**	**48**	**67,503**	**67,439**	**64**
Non Pay Costs									
Clinical Suppplies	704	711	(7)	7,770	7,884	(114)	8,471	8,590	(119)
Non-Clinical Supplies	508	486	22	5,692	5,576	116	6,197	6,064	133
CNST	1,311	1,311	(0)	14,417	14,417	0	15,728	15,728	0
Premises & IT Costs	438	499	(61)	4,818	4,985	(167)	5,268	5,449	(182)
Service Contracts	611	623	(12)	6,483	6,657	(174)	7,110	7,253	(143)
Total Non-Pay Costs	**3,571**	**3,629**	**(58)**	**39,182**	**39,519**	**(338)**	**42,774**	**43,085**	**(311)**
Total Expenditure	**9,180**	**9,207**	**(27)**	**101,106**	**101,395**	**(290)**	**110,277**	**110,524**	**(247)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M11
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	(3,661)	(3,605)	(57)	(41,765)	(41,359)	(407)	(45,612)	(45,062)	(550)
Expenditure	1,698	1,597	101	18,699	18,618	82	20,398	20,130	268
Total Maternity	**(1,963)**	**(2,007)**	**44**	**(23,066)**	**(22,741)**	**(325)**	**(25,214)**	**(24,932)**	**(282)**
Gynaecology									
Income	(2,063)	(2,033)	(31)	(23,567)	(23,641)	74	(25,742)	(25,738)	(4)
Expenditure	859	822	36	9,458	9,429	29	10,317	10,306	11
Total Gynaecology	**(1,204)**	**(1,210)**	**6**	**(14,109)**	**(14,212)**	**103**	**(15,425)**	**(15,431)**	**7**
Theatres									
Income	(42)	(38)	(3)	(457)	(423)	(34)	(499)	(462)	(37)
Expenditure	640	602	38	7,039	7,009	31	7,679	7,614	66
Total Theatres	**598**	**563**	**35**	**6,582**	**6,586**	**(4)**	**7,180**	**7,152**	**28**
Neonatal									
Income	(1,349)	(1,391)	42	(14,895)	(15,340)	446	(16,249)	(16,673)	425
Expenditure	945	968	(23)	10,396	10,524	(128)	11,341	11,481	(140)
Total Neonatal	**(404)**	**(423)**	**19**	**(4,499)**	**(4,817)**	**318**	**(4,908)**	**(5,192)**	**285**
Hewitt Centre									
Income	(800)	(890)	90	(9,070)	(9,220)	150	(9,971)	(10,154)	183
Expenditure	623	687	(65)	6,848	6,998	(150)	7,471	7,649	(178)
Total Hewitt Centre	**(178)**	**(203)**	**26**	**(2,222)**	**(2,222)**	**(0)**	**(2,501)**	**(2,505)**	**5**
Genetics									
Income	(600)	(560)	(41)	(6,604)	(6,484)	(120)	(7,204)	(7,066)	(138)
Expenditure	461	479	(18)	5,074	4,844	230	5,535	5,297	238
Total Genetics	**(139)**	**(81)**	**(58)**	**(1,530)**	**(1,640)**	**110**	**(1,669)**	**(1,769)**	**100**
Clinical Support									
Income	(24)	(24)	(0)	(270)	(307)	38	(295)	(331)	36
Expenditure	759	734	25	8,404	8,226	178	9,164	8,963	200
Total Clinical Support & CNST	**735**	**709**	**25**	**8,135**	**7,919**	**216**	**8,869**	**8,632**	**237**
Corporate & Trust Technical Items									
Income	(825)	(903)	78	(6,493)	(6,686)	194	(7,037)	(7,839)	803
Expenditure	3,721	3,869	(148)	40,982	41,479	(498)	44,702	45,328	(626)
Total Corporate	**2,896**	**2,966**	**(71)**	**34,488**	**34,792**	**(305)**	**37,666**	**37,489**	**177**
(Surplus) / Deficit	**341**	**315**	**26**	**3,779**	**3,665**	**114**	**3,998**	**3,443**	**555**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M11
YEAR ENDING 31 MARCH 2018

BALANCE SHEET £'000	YEAR TO DATE Opening	M11 Actual	Movement
Non Current Assets	**72,688**	**72,175**	(513)
Current Assets			
Cash	4,897	7,296	2,399
Debtors	8,201	7,120	(1,081)
Inventories	366	450	84
Total Current Assets	**13,464**	**14,866**	**1,402**
Liabilities			
Creditors due < 1 year	(10,577)	(17,603)	(7,026)
Creditors due > 1 year	(1,717)	(1,688)	29
Loans	(17,175)	(15,007)	2,168
Provisions	(3,011)	(2,736)	275
Total Liabilities	**(32,480)**	**(37,034)**	(4,554)
TOTAL ASSETS EMPLOYED	**53,672**	**50,007**	**(3,665)**
Taxpayers Equity			
PDC	37,420	37,420	0
Revaluation Reserve	12,233	12,233	0
Retained Earnings	4,019	354	(3,665)
TOTAL TAXPAYERS EQUITY	**53,672**	**50,007**	**(3,665)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M11
YEAR ENDING 31 MARCH 2018

CASHFLOW STATEMENT £'000	YEAR TO DATE M11 Actual	 Forecast
Cash flows from operating activities	(2,098)	(1,734)
Depreciation and amortisation	4,165	4,537
Movement in working capital	7,095	737
Net cash generated from / (used in) operations	**9,162**	**3,540**
Interest received	20	23
Purchase of property, plant and equipment and intangible assets	(3,805)	(6,089)
Proceeds from sales of property, plant and equipment and intangible assets	133	133
Net cash generated from/(used in) investing activities	**(3,652)**	**(5,933)**
PDC Capital Programme Funding - received	0	1,031
Loans from Department of Health - received	500	3,020
Loans from Department of Health - repaid	(2,668)	(2,974)
Interest paid	(166)	(260)
PDC dividend (paid)/refunded	(777)	(1,473)
Net cash generated from/(used in) financing activities	**(3,111)**	**(656)**
Increase/(decrease) in cash and cash equivalents	**2,399**	**(3,049)**
Cash and cash equivalents at start of period	4,897	4,897
Cash and cash equivalents at end of period	**7,296**	**1,848**

Agenda Item	2018/103

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Trust Board Assurance Framework Update**
DATE OF MEETING:	Friday, 06 April 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Julie King, Acting Director of Nursing and Midwifery
AUTHOR(S):	Christopher Lube, Head of Governance and Quality
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:
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:-….)***	***1. Note the assurance presented re process and proposal(s) within this report.*** ***2. Advise the Governance team of approval /views in respect of the process, proposals and rationale***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee Quality Committee
	Date of meeting	Monday, 26 March 2018 Monday, 19 March 2018

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.

Proposed changes are collated through the Head of Governance, who ensures that these are reflected on the BAF dashboards presented to Board and the sub-committees in reports such as this, for their further review. The Governance team are also able to ensure alignment between these dashboards and the risk record on the Ulysses system.

Report

1. Introduction

Following revision of the Board Assurance Framework, this report seeks to assure and inform the Board of the process and outcomes from Board and sub-committee review of risks assigned to the Board Assurance Framework. Any changes in risk score or escalation / de-escalation proposals made by sub-committees after consideration of risks within their remit are conveyed via the Head of Governance to ensure reflection of proposed and approved changes in both the BAF dashboards and the Ulysses Risk record.

The current BAF is embedded below; the proposed and effected changes are highlighted in yellow for ease of reference.

BAF Risks – April 2018:

BAF March 2018#2018-03-22 (S

2. Sub-Committee Changes to Risks

Since the last report to the Board, the sub-committees have further reviewed the risks within their remit and proposed changes as described below:

There have been minor changes to the BAF risk currently on the register and these mainly relate to identifying completed action which can be removed following board review and review of action dates, some of which have had a new revised date added. All changes are highlighted in yellow and underlined for revised information and scored through to be removed.

3. New Risks and Closed Risk

Since the last report, one new risk 2184, the implementation of the Electronic Patient Records system has been identified as a risk and added to the BAF following discussions at executive director team meeting and Quality Committee and Finance, Performance and Business Development Committee. This risk is to be monitored via the Quality Committee with input from the Finance, Performance and Business Development Committee in relation to financial impact of non-achievement as per plan.

No BAF risks have been closed since the last report to the Audit Committee.

4. Conclusions / Recommendations

The report reflects ongoing review of BAF Risks by the Board sub-committees and the resulting changes to scores mitigation and supporting corporate and service risks in accordance with the review and escalation and de-escalation processes.

The Board are asked to:

1. Note the assurance presented re process and proposal(s) within this report.
2. Advise the Governance team of approval /views in respect of the process, proposals and rationale.

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: Putting People First (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 • Reward and recognition processes linked to values • Retention Strategy reviewed annually • Retirement Intentions annual exercise • Pay progression linked to appraisal and mandatory training compliance. • Targeted OD intervention for areas in need of support • Management Development Training Programme • Aspirant Talent Programme for aspiring ward managers and matrons • Programme of health and wellbeing initiatives • All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities. • Extensive mandatory training programme available • Value-based recruitment & induction • Workforce planning processes in place to deliver safe staffing • Investment in engagement tool (2018) • Shared decision making with JLNC & Partnership Forum • Putting People First Strategy • Quality Strategy 2017-2020 • Staff engagement programmes • Freedom to Speak Up Guardian (2nd Guardian in process of being appointed) • Whistleblowing Policy • Guardian of Safe Working	• Quality of appraisal • Poor attendance at non-mandatory training eg. leadership training • Requirement for further development middle managers • 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 • Ongoing challenges of engaging effectively with all staffing groups due to rota patterns	**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) • Exec Team review of Retention Strategy – Dec 2017 **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~~ • ~~Implement talent management tool~~ • ~~Deloitte funding to complete board development work~~ • Putting People First Strategy – in year objectives • Implement Quality Strategy objectives (experience domain) • Develop programme of Development Centres • Aspirant Managers programme being rolled out • Executive Team and staff side walkabouts	• Monthly monitoring • ~~Completed~~ • ~~Completed~~ • ~~Completed~~ • Mar-18 (6 and 12 months reviews) • Mar-18 (6 and 12 months reviews) • Q2 2018/19 • Monthly monitoring 2018 • Monthly monitoring 2018
Risks from Risk Register • 8 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'. • POPPY study • RCM culture survey findings due Q1/2 2018	**Outcome Gaps** • Staff Survey Engagement score not improved in year • 2016 – awaiting 2017 results • 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 develop a well led, capable, motivated and entrepreneurial **workforce**

Risk Appetite: Moderate

Objective: Fully Resourced, Competent & Capable Junior Medical Workforce

CQC Domain: Well-Led

Enabling Strategy: Putting People First Strategy

Operational Lead: Susan Westbury

Assurance Committee: Putting People First (PPF)

Executive Lead: Michelle Turner

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks – 1743 **Condition:** Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. **Cause:** Health Education North (HEN) has the inability to recruit sufficient junior medical staff to cover all Trust rotas across the region due to the national shortage of junior doctors. **Effect:** Insufficient junior medical staffing numbers to ensure patient safety and workforce wellbeing. Insufficient numbers to facilitate all junior doctors training. **Impact:** May result in unsafe care to patients. May result in funding withdrawn from HEN if junior doctor training not met. May result in increased sickness absence and clinical incidents.	• Annually agreed funding contract with HEN • Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer. • Lead Employer notifies the Trust of gaps in local rotations, giving the Trust autonomy to recruit at a local level in to these gaps. • Effective electronic rota management system implemented in 2015. • Consultant Rota Leads appointed for management of junior doctor rotas within all specialties. • Newly appointed Director of Medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN • Guardian of Safe Working Hours appointed in 2016 under new Junior Doctor Contract (2016). • Exception Reporting system implemented under the new Junior Doctor Contract (2016) in relation to hours worked, training and safety • College Tutors in each specialty to ensure junior doctors have sufficient opportunities to meet their training objectives. Escalation system in place to DME or Guardian of Safe Working Hours. • Junior Doctor Forum held	• Further utilisation of the rota management system	**Management assurance** • Quarterly reporting by Guardian of Safe Working to JLNC, PPF and the Lead Employer. • Annual report to Board by the Guardian of Safe Working. • Escalation process in place for Exception Reporting to the Medical Director • DME reports to HEN on an annual basis in relation to junior doctor training • Junior Doctor Forum with Executives • Junior Doctor Contract (2016) fully implemented with Lead Employer • Junior Medical Staff – annual internal staff survey • Compliance with GMC Revalidation requirements (PPF - Sep'16, item 16/17/73) • Key Workforce Risks & Mitigating Actions paper to PPF 09/2017. **Metrics** • Exception reporting data • Monitoring exercise data • Absence data from Lead Employer • Whistleblowing reports	**Assurance Outcomes /Gaps** • New Exception Reporting system and process working effectively. • Action plan from Key Workforce Risks & Mitigating Actions paper 09/2017 being progressed • Junior Medical Staff GMC survey reported to Education Governance & PPF – no areas of specific concern identified	• HEN Action Plan 2016 being implemented • Clinical & nursing roles being developed and enhanced to mitigate the gaps in the junior doctor workforce. Roles include; Physician Assistants, Surgical Assistants, ANP's, Consultant Nurses, ER Practitioners. • ~~Potential development of a regional Trust grade rotation programme~~ • New programme with Hewitt Centre for recruitment of Drs from India	• Monthly monitoring • Monthly monitoring • ~~Not progressing to be removed~~ • Monthly monitoring

	Risks from Risk Register • 1731 - Insufficient clinical staff to meet recommended staffing levels (Corporate Risk) • 1709 - Insufficient consultant or senior medical cover (Corporate Risk) • 9 x Service Risks	quarterly for concerns to be raised. • Remediation Policy. • Monitoring exercises undertaken on annual basis to ensure compliance on junior doctor rotas • Acting-down policy and process in place to cover junior doctor gaps • National Medical Revalidation process ensuring competent doctors • Annual Workforce Planning exercise with operational and clinical teams • Shared decision making and review of risks with Joint Local Negotiating Committee • Putting People First Strategy • Quality Strategy 2017-2020		**Independent / semi-independent** • GMC Revalidation process. • HEN visit – regular (next due 2019 due to satisfactory report in 2016). • GMC Medical Staff survey - annual	**Outcome Gaps** None identified at this time		

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 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: Jenny Hannon

Operational Lead: Janet Parker

Assurance Committee: Finance, Performance, & Business Development (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.	• 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 and NHS England • 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 • Advisors with relevant experience (PWC) engaged early to review strategic options • Clinical engagement and support for proposals • Review of open claims and legal processes	• 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 • Establishment of governance procedures to manage the merger transaction • Merger dependent on external partners	**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) •SOC for preferred option proved by Board – Sep 17	**Gaps** • Final approval for business case	• 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	• June 18 (revised date) • August 18 (revised Date) • Dec-18 (revised date) • Apr-19 (revised date) • Apr-19 (revised date) • Apr-18 to Apr 23
Risks from Risk Register • 7 x Service Risks			**Metrics** • Monthly formal data submission • Long term financial projections **Independent / semi-independent** • CCG Pre Consultation Business Case, approved by CCG Committees in Common • Northern Clinical Senate Report supporting preferred option	**Outcomes** • Delivery of a surplus • NHS I use of resources rating above 2 over a five year time period • Clinical Senate Report – Sept 17 • Reduction in CNST Premium • Reduction in back office overhead costs		

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

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

Objective: Deliver the annual financial plan

CQC Domain: Well-Led / Effective

Enabling Strategy: Operational Plan

Executive Lead: Jenny Hannon

Operational Lead: Janet Parker

Assurance Committee: Finance, Performance, & Business Development (FPBD)

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 2168 **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 Improvement • Internal audit reviews of systems and controls	• None identified at this time	**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 •Internal audit report provides significant assurance (Oct 17)	**Gaps** • Assurance is available re: controls but not on delivery	• Ongoing review of position • Quality performance challenge meetings • Regular Turnaround and transformation meetings • Ongoing review of CIP • Monthly budget meeting with variance analysis.	Monthly monitoring
Risks from Risk Register • 1663 – Operational grip on the creation and delivery of a financially sustainable plan (Corporate Risk)			**Metrics** •Monthly financial data **Independent / semi-independent** • Monthly reports to NHSI with feedback • Internal audit review of budgetary controls • External audit opinion •	**Outcomes** • Delivery of £4m deficit in 17/18 • Delivery of £3,7m CIP for 2017/18 • NHS I Use of Resources Risk Rating – 3		

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

FPBD committee have reviewed score and recommend reduction in likelihood to 3 from 4 therefore reducing score to 15 from 20.

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:** Quality Committee (QA) (Replaced GACA Jan 2018)

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 • Environmental risk assessments • Professional standards • Leadership & Management Development Programme • Acuity exercises • Clinical risk assessments • Engagement with other acute providers for diagnostic and treatment services • Contract in place for cancer patients to be operated on at RLH on a regular list • Programme for the establishment of single service for Neonates with AHCH • Programme for expansion of NICU on site due to ICC risks. • CQC unannounced and Well Led visits completed by March 2018	• Clinical case for change is dependent on decision making external to the trust (CCG, NHSI, NHSE) • Financial constraints for delivery of facilities improvements • Lack of Staff Retention Policy • Capacity and access to Leadership & Management Development Programme •	**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) **Metrics** •Performance monitoring of patient experience and clinical outcomes •Incident Data (including SIs / Never Events) •Safe staffing levels •Transfers out •Data reviewed regularly and reported through HDU group **Independent / semi-independent** • CQC Inspection (2015) • Review of fire provision • Vanguard review of Maternity Base • Neonatal ODM • Maternity SCN Dashboard • Clinical senate report • NICU SOC • Neonatal peer review Jan 18	**Gaps** • ~~Most recent CQC inspection was 2 years ago and Safe domain required improvement (awaiting unannounced CQC visit Jan 18, Announced well Lead visit Feb 18)~~ • Gaps in fire provision (SLA with Aintree estates in place, review completed and risks assessed with generation of priorities presented to Exec Dir) – Jan 18) **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	• Capital plan re: fire provision • Agree a business case for a new build • Commence public consultation • Update operational plan	• May 18 (revised Date) • Monthly monitoring (external lead) • Monthly monitoring (NHSE lead) • April 18
Risks from Risk Register • 12 x Corporate Risks (1597,1736, 1737, 1936, 1964, 2084, 2085, 2086, 2087, 2089, 2090, 2092)						

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	5	20

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:** Quality Committee (QA) (Replaced GACA Jan 2018)

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 • Serious Incident Feedback Form • Serious Incident Panels • Corporate level engagement by board • Listening events • Never events reported through Safety Senate and BoD	• Inconsistent completion and dissemination of actions and improvement plans. • Limited evidence of Patient Safety walkarounds. • Inconsistent implementation of lessons learnt and lack of evidence • 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 in progress of being delivered • In some instances there is a lag with SI process (low in numbers)	**Management assurance** •CQPG (Jan 2018) •CQC Engagement Meeting (Mar' 2017) •Performance Report (BoD – Apr' 2017, item 17/18/xx) •Never Events (BoD – Mar' 2017, item 16/17/xx) •Reporting of incidents and management of action plans through Safety Senate •Reflection of risks and Cooperate Risk Register and Board Assurance Framework	**Gaps** • Inconsistent use of benchmarking tools • 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. • External and internal reporting structures	• Individual assessment of culture across the organisation (risk maturity). • Maintain close involvement with regional and local safety collaborative • ~~Review local governance practice~~ • Additional support and training for risk management / internal review required • ~~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~~ • Further develop safety walkrounds • Review current risk management training for all staff • Develop annual report for Never Events including external information to identify further learning. • Review current SBAR and 72 hr rapid reporting system – clarity required / possible amalgamation	• Dec-18 (revised date) • Monthly monitoring (revised date) • ~~Completed~~ • Sep 18 (revised date) • ~~Completed~~ • ~~Completed~~ • ~~Completed~~ • Sept 18 • Oct 18 • July 18 • June 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 • Quarter reports to CCG • Benchmarking through VON, EMBRACE **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 • MIAA report on Duty of Candour • Safety Senate Report	**Outcomes** • CQC visit completed		

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: Julie King | **Operational Lead:** Christopher Lube | **Assurance Committee:** Quality Committee (QA) (Replaced GACA Jan 2018)

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 • 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 • National audits • Local audits • Ward accreditation scheme in place • Quality and independence of QIA's by DoN and MD • External peer reviews	• Benchmarking data can make the trust appear an outlier due to the specialist nature of the services provided and attract regulatory attention • All Fundamental Standards need to be allocated an Executive, Non-Executive and Operational lead; • Lack of patient safety walkroudns by Execs	**Management assurance** • NHS Improvement monthly returns • Mock Inspection Report (GACA – Jan' 2017, item 16/17/xx) • MIAA Audit • CQC Visit • CCG Meetings monthly	**Gaps** • Regular internal monitoring of professional and regulatory standards	• Regular review of compliance position • Further develop patient safety walk rounds • Provide assurance to CQC in relation to risks with appropriate information.	• Monthly monitoring (revised date) • July-18 • As and when required
Risks from Risk Register • 1736 Business Continuity (Corporate Risk) • 2074 Fire Regulations (Corporate Risk) • 1734 Repeat can costly events (Corporate Risk) • 1966 Risk of safety incidents (Corporate Risk)			**Metrics** • Internal audit metrics • High level performance metrics **Independent / semi-independent** • Internal Audit Report (Mar-17) • CQC Inspection Report (2018)	**Outcomes** • Awaiting CQc report • Collaborative meetings with CCG		

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 deliver **safe** services
Risk Appetite: Low

Objective: Long-term clinical sustainability | **CQC Domain:** Safe | **Enabling Strategy:** Risk Management Strategy / IM&T Strategy

Executive Lead: Andrew Loughney | **Operational Lead:** David Walliker | **Assurance Committee:** Quality Committee (QC)

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks – 2184 **Condition:** Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) **Cause:** Poorly designed and implemented system **Consequence:** • Impact on Patient Safety • Impact on patient and clinical services, such as e-prescribing, staff documentation and consent. • Unable to meet contractual reporting arrangements linked to STF • Financial impact on delivery of control total leading to inability to deliver annual plan 2018/19	• EPR programme board • Monthly EPR meetings chaired by AUHT CEO with LWH Exec Dir representation. • Governance structure for project in place • LWH Digital sub-committee in place with DoF chairing • Monthly IM&T mangers operational meetings in place • PID in Place • Testing programme for system in place prior to implementation • Communication plan in place • Benefit Strategy • Clinical leadership identified • Training plan in place	• Concern as to supplier management • Programme board ineffective • Test cycle may be ineffective and if not signed off will impact on programme • Unable to train staff until system has been signed off which may lead to a delay	**Management assurance** • Executive Sign off • Clinical (operational) sign off • Regular report form digital group through up to executive directors • Bi-weekly Exec Team Briefing • FPBD will continue to receive assurance on delivery of EPR through the digital hospital subcommittee and if there are any risks of delivery etc. these will be reported to the QC.	**Gaps** • Concern related to supplier • Functionality of modules for Maternity, Theatres and e-prescribing • What is being built is not what Trust was expecting Effectiveness an timing of Training plan	• ~~Appointment of a programme manager~~	• **~~Completed, commence in Post wc 19-02-18~~**
			Metrics • Monthly reports to show progress against plan • Highlight report presented against milestones • Monthly review at FPBD	**Outcomes** • Full implantation of EPR against planned date • No impact on the delivery of £4m deficit in 17/18 • Supports the delivery of £3,7m CIP for 2017/18	• Implementation of MIAA action plan • Delivery of test cycle plan • Completion of repeat audit by MIAA • Delivery of programme action plan and relevant sub logs • Completion of business intelligence strategy	• Feb - 18 • April - 18 • May - 18 • Oct - 18 • Oct - 18
Risks from Risk Register • 2024 – IM&T service risk			**Independent / semi-independent** • MIAA Report (limited assurance) 2017 • Gateway process in place with external verification			

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**	4	5	**20**	4	4	**16**

Updated following review by Board of Director 2nd March 2018

Reviewed by Sub-Committee of the Trust Board – March - version 1.0

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: Julie King

Operational Lead: Devender Roberts

Assurance Committee: Quality Committee (QA) (Replaced GACA Jan 2018)

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 2168 **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 2017 • 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 • Performance data presented at Clinical Comm Meetings	• Further improvements to be made in relation to 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. (indicated time is allocated in Consultant job plans for this activity) • 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 • External auditors programme (KPMG) **Metrics** • Mortality metrics • Never events • Incident data • Quality Strategy metrics • CQUINS • Performance data	**Gaps** • Difficult to gain consistent assurance that clinicians are following best practice • Lack of Lack of available benchmarking data due to nature of specialist services provided • 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	• ~~Completed June 17~~ • ~~Completed June 17~~ • ~~Completed June 17~~ • ~~Completed June 17~~ • Revised to April 18, in progress • April 18 (revised date) • April -18 (revised date)
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			**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 • CQC inspection visits • CCG monthly quality and performance meetings.	**Outcomes** • CGC rating Good • Neonatal Peer review Jan 18 • Liverpool University Review • Accredited NMC for MSc conversion course		

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: Julie King

Operational Lead: Michelle Morgan

Assurance Committee: Quality Committee (QA) (Replaced GACA Jan 2018)

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 2167 **Condition:** Potential for poorly delivered positive experience for those engaging with our services **Cause:** There are a number of issues impacting on the issue, such as: Capacity and capability of staff, high turnover of staff, poor staff morale, non-acceptance of personal and professional responsibility, excessive waiting time, 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.	• Patient experience strategy • 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 2017-20 • PALS plus • Patient engagement • Use of volunteers • Consistent application of supporting staff policy	• Environment and estates issues require implementation of the PCBC • Confirmation of sustainability of changes and improvements is required • Consistent and accurate data regarding skill mix • Removal of statutory supervision with no agreed model in place • Insufficient quality of interpretation services	**Management assurance** • Patient stories to Staffing levels (reports to board) • Staffing red flags (reports to board) • Patient Opinion (monthly to board) • PLACE Assessment • Health watch peer review • Governor experience and safety committee in place • Daily Huddle	**Gaps** • Out of date policies • Put of date patient information leaflets	• Consider how to enhance assurance levels around the involvement of hard to reach groups. • Ensure all staff , Trust members and volunteers have 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) • ~~HoM proposal to continue process of midwifery supervision and plan presented to CCG~~ • ~~Review of current interpretation service provision~~	• July-18 (revised date) • Sep-18 (revised date) • ~~Completed Dec 17~~ • ~~Completed Nov 17 (local tool in place)~~ • Ongoing (revised form specific date) • Completed • ~~Completed – new provider identified and funding agreed – mobilisation to be commenced.~~
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 results awaited		

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**