Meeting of the Board of Directors
HELD IN PUBLIC
Friday 4 May 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
116	Apologies for absence Declarations of interest	Receive apologies	Verbal	Chair		-
117	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		Well Led
118	Patient Story	To receive a patients story	Presentation	Val Irving, Matron for Neonates	1010 (20mins)	Safe, Experience, Well led
119	Minutes of the previous meeting held on 6 April 2018	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1030 (5mins)	Well Led
120	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written/verbal	Chair		Well Led
121	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1035 (10mins)	Well Led
122	Chief Executive Report	Report key developments and announce items of significance not elsewhere	Written /Verbal	Chief Executive	1045 (10mins)	Well Led

BOARD COMMITTEE ASSURANCE						
123	Chair's Report from Putting People First Committee	Receive assurance and any escalated risks	Written	Committee Chair		Well Led
124	Chair's Report from Finance, Performance and Business Development Committee	Receive assurance and any escalated risks	Written	Committee Chair		Well Led
125	Chair's Report from Quality Committee	Receive assurance and any escalated risks	Written	Committee Chair	1055 (15mins)	Safe 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						
126	Whistleblowing and Speak Up Guardian Annual Report	Receive assurance and any escalated risks	Written / Presentation	Director of Workforce and Marketing	1110 (20mins)	Well Led
127	Mortality Report	To review and be sighted on	Written	Medical Director/ Associate Medical Director	1130 (10mins)	Safe Well Led
128	Corporate Objectives 2017/18 and 2018/19	To review and approve	Written	Chief Executive	1140 (10mins)	All
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES						
129	Safer Nurse/Midwife Staffing Monthly Report 12	Receive assurance and any escalated risks - The Board is asked to note the content of the report	Written	Acting Director of Nursing and Midwifery	1150 (5mins)	Safe Well Led
130	Performance Report period 12, 2017/18	Review the latest Trust performance report and receive assurance	Written	Director of Operations	1155 (10mins)	Well Led
131	Finance Report period 12, 2017/18	To note the current status of the Trusts financial position	Written	Director of Finance	1205 (10mins)	Well Led
TRUST STRATEGY						
BOARD GOVERNANCE						
132	Risk Appetite Statement 2018/19	To approve	Written	Director of Nursing and Midwifery	1215 (5mins)	Well Led

133	Board Assurance Framework	Receive assurance and any escalated risks against corporate risks	Written	Trust Secretary	1220 (15mins)	Well Led
134	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair		Well Led
HOUSEKEEPING						
135	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1230 Meeting ends	Well Led

Date, time and place of next meeting Friday 1 June 2018

Meeting to end at 12:30

1230-1245	Questions raised by members of the public observing the meeting on matters raised at the meeting.	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Board Agenda item 2018/119

Board of Directors

Minutes of the meeting of the Board of Directors
held in public on Friday 6 April 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 Tony Okotie	Non-Executive Director/SID

IN ATTENDANCE

Mr Colin Reid	Trust Secretary

APOLOGIES

Mr Phil Huggon	Non-Executive Director

2018

Thank You
Individual Board thank you.

The Director of Nursing and Midwifery thanked on behalf of the Board Sharon Owens, Emergency Department Manager, Gynaecology for stepping up into the role of matron. Sharon is a long serving staff employee who always puts the needs of the patient at the heart of what she does.

The Director of Nursing and Midwifery and Director of Finance thanked on behalf of the Board Rachel London, HR Business Partner. Rachel is a dedicated HR manager who is dedicated to her role and provides excellent advice and support. She is fair minded and able to look past issues to find the right path to follow.

089 **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.

090 **Meeting guidance notes**
The Board received the meeting attendees' guidance notes.

091 Patient Story

The Board received a patient story from Julie Patient, Gynaecology Oncology, supported by Chris Webster, Macmillan CNS and Lead cancer nurse, Gynaecology Oncology. Julie provided the Board with her story as a patient of the Trust and advised on the excellent care she had received both at the Trust and at other NHS providers since she was diagnosed with ovarian cancer. Julie thanked all the members of staff who had been fabulous in the provision of her care. She explained that at no time did she feel anxious, vulnerable or that any loss of dignity given the support packages surrounding her care.

Julie recognised the need for her to attend different service providers as part of her care however she felt that a 'one stop shop' would have been better for patients, although this did not detract from the care and support that was afforded to her.

The Chair thanked Julie for her story and was pleased that she provided such positive comments to the care she had received not only from within the Trust but also at other services provider in the region.

The Chief Executive referred to the fantastic care that had been provided and noted that the future direction of the Trust would mean that patients would not be required to be taken from one location to another for care, as this could be provided by Trust's within the same location on one site. The Medical Director supported the comment noting that there was some considerations being given by NHS England surrounding the future provision of one stop shops. This was something that was on his radar as a potential risk to the future provision of Gynaecology services should the trust remain on an isolated site.

092 Minutes of previous meeting held on Friday 2 March 2018

The minutes of the meeting held on 2 March 2018 were approved.

093 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.

094 Chair's Announcements

The Chair advised that he had undertaken a shadow session recently with Community Midwife Jo Elliott who works out of St Chads Walk-in Centre. He advised on the activity and advised that Jo was a shining example of a dedicated midwife, with quite a high case load who knows her patients and community well and it was very apparent her community knows her. She delivered care, collected and delivered information, reassured, advised and referred on with thoughtfulness and professionalism for all her patients.

The Chair advised on his observations advising on how much community midwives depended on a paper system and felt that when implementing the new EPR system the Trust had to be mindful of this and felt that they, the community midwives, would need to have a lot of support. He felt that the Board needed to assure itself that the new systems work for all staff and that the community staff would have particular requirements. The Chair went on to advise on other observations which he had passed to the Director of Operations following the Board visit to the Centre in November 2017.

The Chair advised on his attendance at the NHS England NED Learning event which was also attended by David Astley and Ian Knight. He advised that the day was themed 'Learning from Experience' and focused on learning from the experiences of families involved in serious incident investigations with powerful personal experiences of family and child death. The day looked at how to involve families of patients and what good serious incident investigations should look like; what NEDs should look for and challenge on at committee and board meetings; and this then developed on to what good

governance processes and structures looked like (as defined by the Good Governance Institute).

Referring to the Council of Governors, the Chair advised that the next meeting of the Council was 25 April 2018 and asked that Directors attend the meeting. He commented on the work of the Council groups which he felt were working well and able to provide assurance to the Council on key matters affecting the Trust. The Trust Secretary provided a verbal update on the Governor elections that were due to be held during the summer 2018 and advised that the outcome of the elections would be announced at the Annual Members Meeting (AMM) on 13 October 2018.

The Chair referring to the AMM advised that the Trust would be looking to celebrate the NHS 70th birthday on that day and Governors had been asked to support the Trust Secretary and Head of Communications developing a plan for the day.

The Board noted the Chair's verbal update.

095 **Chief Executive's report**

The Chief Executive referred to her report and advised on the following.

2018 Dedicated to Excellence Awards: The Chief Executive reminded the Board that the awards would take place on Friday 20th April 2018 with 10 categories that includes two new categories: Dedicated to Clinical Audit; and Staff Fundraiser of the Year. She advised that the awards showcased the excellent work the Trust staff did throughout the year.

Establishment of the Edge Hill University Medical School: The Chief Executive advised that Edge Hill University had recently received validation from the GMC for the establishment of the Edge Hill University Medical School, with the first intake for the new school in September 2020. She congratulated Edge Hill on the achievement and advised that the Trust would be looking at how it could support the medical school.

Governments Mandate to NHS England and Remit to NHS Improvement 2018-19 NHS mandate – The Chief Executive referred the Board to NHS England's mandate setting out the key deliverables and goals for NHS England and NHS Improvement and referred to the paper included in the report regarding the closer working arrangements for NHSE and NHSI.

Gender Pay Report: The Trust Gender Pay Report had been published on the Trust web site and had been available from 30 March 2018. The Director of Workforce and Marketing advised that the Putting People First Committees would be reviewing the findings in more detail and any required actions from the review.

National Workforce Strategy Trust: The Director of Workforce and Marketing provided a verbal update on the trust's response to the National Workforce Strategy. She advised that the Putting People First Committee had been involved in the response and any feedback from the consultation would be considered by the Committee once it was received.

The Board noted the Report from the Chief Executive.

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

Susan Milner, Chair of the Quality Committee highlighted the work of the Committee at its meeting on 19 March 2018 and advised that the Committee had received assurance from the Director of Operations that action plans were in place to address the two Serious Incidents (SI) relating to 62 day Cancer and RTT breaches. The Committee had noted that a full SI review was being undertaken for both incidents with the panel meeting arranged for 16 April 2018. The Committee recognised the importance of one of the Board Committees would be actioned to monitor the action plans and that

this would be undertaken by the FPBD Committee however the Quality Committee would receive reports that impact on quality, safety and patient experience.

Referring to the Clinical Audit Programme Susan Milner advised that the Committee had reviewed the work plan for 2018/19 and had noted that each audit would be risk assessed so that a priority could be set for each given the number of audits included in the plan. The Committee had noted that the Effectiveness Senate would review each Audit and any escalation issues would be reported to the Committee through the Effectiveness Chairs Report, with an end of the year Clinical Audit Annual Report presented to the Committee for review.

Susan Milner advised that as part of the Trust's risk management strategy each Board committee undertakes a review of the Trust's Risk Appetite Statement that relates to their area of responsibility prior to going to the Board. She reported that the 2018/19 Risk Appetite Statement had been reviewed and the finding of the review was contained in the Report: This would be brought together at the May Board with the other Committee's statement to provide the overall Trust Risk Appetite Statement 2018/19.

Susan Milner advised that the Committee undertook a review of the Committee's terms of reference and work plan noting that they had only recently been reviewed in December 2017, noting the reason for this was to bring in line the review with other Board committees. She advised that the terms of reference were presented for approval of the Board.

Susan Milner advised that there were no changes made to the BAF.

The Chair thanked Susan Milner for her report which was noted. The Board approved the amended Terms of Reference of the Quality Committee as presented in the report.

097 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 26 March 2018 and ran through the key areas of work and assurance received by the Committee. In particular Jo Moore advised that the Committee, as with the Quality Committee had received an update on the actions taken to address the 62 day Cancer and RTT breaches which had resulted in STEIS reports. She explained that the Committee had received an update on changes made to the management team structure to support recovery and what the potential recovery costs would be. Jo Moore advised that the deadline to resolve both issues was July 2018.

Referring to Month 11 2017/18 Finance Performance, Jo Moore advised that the Trust was on trajectory to deliver the forecast deficit for the year of £3.4m and that the Trust would deliver its CIP target for the year.

Jo Moore advised that as the Committee charged with the responsibility to review the implementation of the Electronic Patient Record (EPR) system she advised that timescales for implementation remained October 2018 and confirmed that a full report would be brought to the Board following review in May. Referring to the GDE Fast Follower funding and expenditure, Jo Moore advised that the Committee had received detail of the investment requirements against the GDE funding agreement and had noted the procurement of IT solutions towards deployment of the GDE programme. With regards to the Neonatal Capital Build, the Committee had received a progress update and noted that the Director of Operations would Chair the Project Board to deliver the programme.

Jo Moore advised that, as with the Quality Committee, the Committee had reviewed its element of the Trust's Risk Appetite Statement 2018/19; the findings of the review was included in her report. A review of the Terms of Reference and Business Cycle was also undertaken and Jo Moore advised that

the terms of reference were presented to the Board for approval of the Board.

Jo Moore advised that there were no changes made to the BAF.

The Chair thanked Jo Moore for her report which was noted. The Board approved the amended Terms of Reference as presented in the report.

098 Chair's Report from the Audit Committee

Ian Knight, Chair of the Audit Committee presented his report on the work and assurances the Committee had received at it meeting on 26 March 2018 and highlighted the following:

The Committee had received an updated position on outstanding recommendations in the Follow up of Internal Audit and External Audit Recommendations report.

The Committee had received assurance from Internal Audit that the Board Assurance Framework was structured to meet the NHS requirements and was visibly used by the Board and clearly reflects the risks discussed by the Board.

The Committee had reviewed amendments proposed to the audit plan for cyber security in light of system changes which was approved noting that the Board would continue to receive assurance regarding IM&T matters through the FPBD Committee.

Referring to the Draft Director of Internal Audit Opinion and Annual Report 2017/18; the Committee noted that the final report would be received in May 2018 with the Annual Report and Accounts noting that the opinion contributes to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control and would assist the Board in the completion of its Annual Governance Statement (AGS). A draft positive opinion was received.

The Committee received an External Audit Update and Technical Update noting that two areas have been identified as significant value for money risks: Financial sustainability and CQC Inspection Response. There was a discussion regarding the potential impact of the recent breach against the 62 day Cancer and RTT target on the Quality Report and Audit Opinion with the Committee being kept informed of progress ahead of the sign-off meeting in May 2018.

The Committee received an annual update on Raising of Staff Concerns and noted that the Trust had received six formal anonymous concerns which had been investigated and no actions taken. The Committee was assured that appropriate policies are in place and that appropriate action was taken to address any concerns raised.

A review of Audit Committee Terms of Reference and Business Cycle was undertaken and are submitted to the Board for approval.

The Chair thanked Ian Knight for his report which was noted. The Board approved the amended Terms of Reference as presented in the report.

099 Annual Staff Survey 2017

Rachel London, HR Business Partner joined the meeting to present the findings of the Annual Staff Survey 2017.

Rachel London presented the finding of the Survey and reported that there had been minimal changes in scores compared to the 2016 Staff Survey; with no deterioration in the responses to questions poised and one improvement relating to "the number of staff who feel confident reporting

unsafe clinical practice". Rachel London advised that one of the key indicators was engagement, defined as would staff recommend the Trust as a place to work or have care or do staff feel motivated and do staff feel they could contribute to improvements at work. Rachel London advised that the Trust's engagement score had slightly increased to 3.8 out of maximum score of 5 compared to 3.77 in 2016.

Rachel London ran through her presentation explaining the key employee engagement questions and the scores and where the Trust was in comparison to other trusts in the region which found the Trust mid table.

Referring to where the Trust had done well, Rachel London advised that: 91% of staff feel there is equal opportunity for career progression; fewer staff have witnessed errors, near misses or incidents (24%); fewer staff have faced discrimination (7%); and fewer staff have experienced violence (3%) and more staff report when they have (81%). Where the Trust could do better, compared to other specialist acute Trusts: staff were less satisfied with the quality of appraisals (2.93 out of 5- highest score in NHS is 3.45); fewer staff would recommend the Trust as a place to work or have care (3.83 out of 5); action on health and wellbeing (3.57 out of 5); fewer staff feel they could contribute to improvements at work (69%); and fewer staff feel communication was effective (31%).

With regards to trends by staff groups, Rachel London reported that highest levels of engagement was reported in Finance, HR, and Medical with the lowest levels of engagement in estates and facilities, pharmacy, scientific/ technical staff and the admin teams. Neonatal Service reported positive scores in all areas, significantly more positive than gynaecology and maternity and Healthcare assistants' engagement was generally more positive than registered nurses and midwives. With regards to well being operational managers, estates and scientists reported highest levels of stress.

Rachel London advised that the focus for 2018 would include: the review of the Putting People First Strategy currently being undertaken would seek to focus on the most important priorities for the organisation; the roll out of the Go Engage Programme; continue with quarterly Listening Events; continue with manager visibility and joint staff side and Board walkabouts; embed the Strategic Workforce Review Group to ensure co-ordinated Trust wide workforce planning; deliver quality improvement training; continue to invest in our Leadership Development – with a focus on talent mapping, succession planning, embed value based reward & recognition; and review effectiveness of PDR training and processes. The Director of Workforce and Marketing advised that these priorities would be discussed and agreed at the Putting People First Committee where the issues would be stress tested.

Ian Haythornthwaite referring to the findings of the Survey felt that considerable focus should be placed on those areas which did not feel engaged or where there was a feeling that communication was not effective. The question on how the Trust engages with staff was discussed and it was noted that technology would need to be exploited to support staff.

The Director of Workforce and Marketing advised that the People Strategy was being developed and would be a 3-5 year Strategy and would take into account the issues raised in the Survey. She advised that the Strategy would be developed with input from staff and other stakeholders through engagement events, such as listening events with review of a draft Strategy at the June 2018 PPF Committee and final sign off by the Board in October 2018.

The Chair thanked Rachel London for her presentation and welcomed the approaches being taken to address the issues raised from the Survey and the approach to the development of the new People Strategy.

100 **Safer Nurse/Midwife Staffing Monthly Report Period 11**

The Acting Director of Nursing and Midwifery presented the Month 11 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.

The Acting Director of Nursing and Midwifery advised that during month 11, the wards were considered safe with low levels of harm and positive patient experience across all inpatient areas indicating that safe staffing had been maintained. She referred the Board to the slight decrease in fill rate within inpatient maternity services which was due to a number of factors including long term sickness, a spike in short term sickness, maternity leave and vacancies. The Acting Director of Nursing and Midwifery reported that recruitment within maternity was ongoing with interviews taking place in April 2018 to address vacancy and maternity leave cover. The Acting Director of Nursing and Midwifery advised that work would continue within gynaecology outpatients to review safe staffing and gynaecology outpatient nursing staffing model however it should be noted that this was not required on the UNIFY return as the return only applies to inpatient staffing.

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

101 Performance Report Period 11 2017/18

The Director of Operations presented the Performance Report for period 11 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 referred to the serious incident reported in February with regard to the accuracy of reporting of the 18 week RTT target. He advised that the Trust had been unable to report an accurate position for January; however the Trust had been able to submit its RTT submission for February which achieved 87% against the target of 92%. The Director of Operations advised that a significant internal validation process (review of 7000 patient records) had been undertaken which he had been able to sign off and in order to provide additional assurance an external audit commenced on the 26th March, 2018 by an independent organisation specialising in access targets. The Director of Operations advised that putting some context to the Trust's performance the national position for RTT for gynaecology in January was 89.3% against the Trust's RTT position of 86.4%; and the all speciality national performance was 88.2% against the Trust's position of 87%. The Board noted that a full report and recovery plan was submitted and discussed at FPBD, as reported earlier in the meeting. He explained that he was confident that the Trust would return to RTT compliance by July 2018.

Referring to the 62 day Cancer target, the Director of Operations advised that the information for January and February had been cleansed and reflected the true position for both GP referral and consultant upgrade; all other months were not accurate and NHSE had not given any indication whether they require a retrospective correction.

The Director of Operations advised that with regards to 62 day Cancer no harm to patients had been identified. He could not at this stage give assurance that there was no harm to RTT patients and explained what was being done to identify if any harm had been caused to patients. The Director of Operations advised that the Trust was carrying out full harm a review which was supported by the regulators.

The Chair thanked the Director of Operations for his report noting that the Board and Board Committees had been receiving updates and welcomed the progress being made in addressing the 62 day Cancer and RTT.

The Board discussed the remaining indicators noting that sickness rates increased in all of the three largest areas: Gynaecology, Maternity and Neonates and that all are in excess of 4.5%; with managers

continuing to actively manage sickness in accordance with the Trust policy.

The Board noted the Performance Report for period 11 2017/18.

102 Financial Report & Dashboard Period 10 2017/18

The Director of Finance presented the Finance Report and financial dashboard for month 11, 2017/18 and reported that at Month 11 the Trust was £0.114m favourable against the planned £3.779m deficit, and was forecasting delivery of the full year control total.

The Director of Finance advised that there were no concerns to flag to the Board surrounding the year end position and that the Trust continued to pay suppliers in accordance with the better payment practice code.

The Chair thanked the Director of Finance for presenting the Financial Report & Dashboard Period 11 2017/18 which was noted. The Medical Director commented on the excellent support the clinical leads had been receiving from the finance team and asked the Director of Finance to pass on his thanks to the team.

103 Board Assurance Framework

The Trust Secretary presented the Board Assurance Framework reporting on the changes that had been made since the previous report was presented. He explained that all changes had been approved by the relevant Board Committee and had been reported to the Board through the Board Committee Chairs Report. The Board noted the EPR risk had been included on the register and the Chair asked that given the trust was at a critical point in the implementation plan it was important that the risk was kept under review.

The Board received the Board Assurance Framework noting that it includes the Key issues and risks that could affect the Trust in delivering its strategic objectives.

104 Review of risk impacts of items discussed

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

- Single Stop Gynaecology site – potential future risk

105 Any other business & Review of meeting

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

The Chair closed the meeting by reminding the Board that it was Ian Haythornthwaite's last Board meeting as a Non Executive Director and thanked Ian personally for his support over the last two years and on behalf of the Board for the past seven years. The Chief Executive added her thanks and that of the Executive recognising Ian's challenging, supportive and balanced manner over the years, particularly in dealing with some very difficult issues.

Date of next meeting

The Chair reported that the next meeting of the Board in public would be 4 May 2018.

Agenda Item 2018/120

Liverpool Women's NHS Foundation Trust

TRUST BOARD
4 May 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~~ TBC	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. It has been agreed to hold a workshop session on the toolkit at a suitable date to be confirmed. This action will be removed from the action log.*
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
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	*This action has been moved to the Quality Committee action plan* 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	*This action has been moved to the Quality Committee action plan*. 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

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Putting People First Committee meeting held 20 April 2018

1. Was the quorate met? Yes

2. Agenda items covered

~ **Review of Risk Appetite Statement 2018/19:** The Committee agreed that there should be an element of risk to allow for improvements to healthcare services for patients. The Committee recommended that the Board should maintain a moderate risk appetite for their objective to develop a well-led, capable and motivated workforce.

~ **Staff Experience Story – MLU Maternity:** The Committee welcomed a newly seconded MLU Ward Manager. She was a scientist by background however changed her career path to become a midwife a couple of years ago since supporting a friend through childbirth and post-natal. She advised that her aim is to drive midwifery process and presence back to the forefront of their care. She explained that the role had been challenging however it was also empowering and she felt she was a valued part of the organisation. The Committee noted that she had trained at another provider but chose to work at this Trust due to the options and choices provided and she appreciates the innovative culture of the department.

~ **Service Workforce Assurance and Risk Report – Maternity:** The Committee noted the headroom position of 18.5% which is proving increasingly difficult for maternity to release staff for mandatory and additional training needs. This is in contrast to Birth Rate Plus staffing tool which sets 21.5% headroom to allow for additional midwifery training needs. The Acting Deputy Director of Nursing and Midwifery advised that finance have been asked to provide the costing to increase the headroom. It is considered that this would not only improve the training requirements for this workforce group but could also improve the culture and sickness rates. The Committee was also asked to note the challenge to implement continuity of carer as mandated by NHS England, which will apply to 20% of bookable women by May 2019.

~ **Director of Medical Education Annual Report:** The Committee noted actions taken to develop education governance and maintain performance.

~ **NHS Staff Survey 2017 results and action plan:** An interactive workshop was held for the Committee to consider two questions: "What can we do to increase staff recommending the Trust as a place for care" and "What can we do to change the staff perception of learning from lessons resulting from incident reporting". The Committee provided their responses which will be included as part of the action plan and inform the refresh of the People Strategy. It was noted that a similar exercise would be undertaken at other forums to capture all staff groups.

~ **Director of Workforce Report:** The Committee noted updates on key issues including successful training of the first cohort of Mental Health First Aiders; achieving 3 awards for work on apprenticeship programmes; and the gender pay reforms report 2018. It was noted that the Trust is not an outlier for gender pay however there would be increased efforts to promote lower banded roles to male applicants and to promote women into leadership roles. This report and associated actions would be reviewed by the Diversity and Inclusion Committee.

~ **Workforce Key Performance Indicator (KPI) Report (Month 12):** The Committee received M12 KPI report. The Committee noted a decrease in sickness levels in month which is consistent with annual data. It was reported that the staff survey question relating to the quality of PDRs is not consistent with the PDR sign off sheet responses which is evidencing a positive outcome. The Head of Learning & Development would continue to review feedback.

~ **Annual Workforce Profile Report 2017:** The Committee noted the key highlights from the annual review. It was noted that there are no concerns in relation to recruitment and everyone who is shortlisted has equal opportunity of selection with no bias. It was noted that a new employment advisor would be working with the Trust to encourage recruitment from all protected groups. It was confirmed that this information will be included within the PPF Strategy.

NHS

- **Settlement Agreements Annual Report:** The Committee noted that the Trust had entered into a total of eight settlement agreements during 2017/18. It was reported that five of these relate to the MARS agreements and three related to resignations of senior members of staff were no payments were involved other than normal contractual entitlements concerning notice and annual leave.
- **Raising Concerns Annual Report:** The Committee noted that a second Freedom to Speak Up Guardian had been appointed which would ensure that the role is accessible to all staff. The team would be relaunched within the organisation with the support of the Communications team.
- **Guardian of Safe Working Hours Quarter 4 report:** It was noted that there had been a reduction in locum usage and rota gaps during quarter 4 2017/18, this is in part due to doctors returning to rotation from maternity leave. The known national shortage of junior doctors remains a risk as detailed on the Trust risk register.
- **Policies for approval:** The Committee reviewed and ratified the Equality and Human Rights policy.
- **PPF Annual Report 2017/18**: The Committee approved the annual report and would submit to the Board of Directors in May 2018.
- **PPF Committee Terms of Reference and Business Cycle 2018/19**: The Committee approved its terms of reference and business cycle and would submit to the Board of Directors in May 2018.
- **Sub Committee Chair reports**
    - Education Governance Committee terms of reference and Chairs report held 15 March 2018
    - Partnership Forum meeting held 26 February 2018
    - Diversity and Inclusion Committee terms of reference and Chairs report held 20 February 2018
    - Joint Local Negotiating Committee meeting held 18 April 2018
    - Nursing and Midwifery Board no meeting held
    - Health and Wellbeing Group no meeting held

The Committee noted and approved the above Chairs reports and terms of reference of its reporting sub-committees.

3. Board Assurance Framework (BAF) risks reviewed

The Committee reviewed the BAF risks it is responsible for on behalf of the Board and recommended a reduction of the current risk score for BAF risk 1744 - to deliver a capable & well-led workforce from 15 to 10. Likelihood 2 x Impact 5 due to assurance outcomes being delivered against the PPF strategy. The Committee considered the target risk score and agreed that it should remain as 10. It was considered a further reduction to this target position over a 12 month period would be over ambitious against the PPF strategy which is set over 3-5 period.

The Committee also considered the risk score position for 2018/19 and agreed the following:
Risk 1744 – Current risk score 10 subject to Board approval, Target risk score to be remain as 10
Risk 1743 – No change to position. Current risk score 20 and Target risk score 10

4. Escalation report to the Board on PPF Performance Measures

See section 2, within Workforce Key Performance Indicator Report Month 12.

5. Issues to highlight to Board of Directors

- Workforce and Assurance Report for Maternity: The Committee wishes to highlight increasing concerns with regards to the headroom within maternity staffing to support mandated training needs.

- Workforce and Assurance Report for Gynaecology: The Committee acknowledges that they did not receive an assurance report at the meeting due to the ongoing recovery work underway. It was assured that the Board is being appropriately informed of developments at Executive Committee, FPBD Committee and at Board of Directors meetings. The Committee noted that the gynaecology

service will be feeling pressure and anxiety from recent events and will require a support mechanism to be in place. The Committee wanted to acknowledge the hard work being undertaken by the leadership team. It was also noted that the maternity division had been in a similar position and the Committee suggested support and guidance could be offered/sought from maternity colleagues.

6. Action required by Board of Directors

- To approve the Putting People First Terms of reference (enclosed)
- To approve the Putting People First Annual Report 2017/18 (enclosed)

AUTHOR NAME: David Astley (Acting Chair)
DATE: APRIL 2018

PUTTING PEOPLE FIRST COMMITTEE

TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Putting People First Committee (the Committee).
Duties:	The Committee is responsible for: a. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process b. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee) c. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce d. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors e. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues f. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys g. Reviewing and approving partnership agreements with staff side h. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues, including but not limited to equality and diversity i. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings j. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where additional assurance is required, escalating to the Board of

	Directors as required. k. Receiving and considering issues from other Committees when appropriate and taking any necessary action.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • 2 other Non-Executive Director • *Director of Workforce & Marketing • *Director of Nursing & Midwifery • *Director of Operations • Staff Side Chair • Medical Staff Committee representative • Senior Finance Manager *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 four members including: • The Chair or at least one other Non-Executive Director • At least one from either Director of Workforce and Marketing or Director of Nursing and Midwifery • Director of Operations or their Deputy • Either Staff Side Chair or Medical Staff Committee representative
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** HR & OD Senior Team, Health & Wellbeing Manager, Education Governance Chair, a representative from the Nursing & Midwifery Board shall normally attend meetings. Members may send a nominated representative to attend meetings on their behalf when they are not available, provided they are sufficiently senior and have the authority to make decisions. Other executive directors, officers and staff 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 at least 4 times per year. 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.
Accountability and reporting arrangements:	The Putting People First Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the subsequent Board of Directors for assurance (see Appendix 1). Approved minutes will be made available to all Board members upon request. Approved chairs reports will also be circulated to members of the Audit Committee. 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 Putting People First 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 Putting People First Committee:	20 April 2018
Approved by Board of Directors:	[May 2018]
Review date:	[April 2019]
Document owner:	Colin Reid, Trust Secretary Email: colin.reid@lwh.nhs.uk Tel: 0151 702 4033

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**

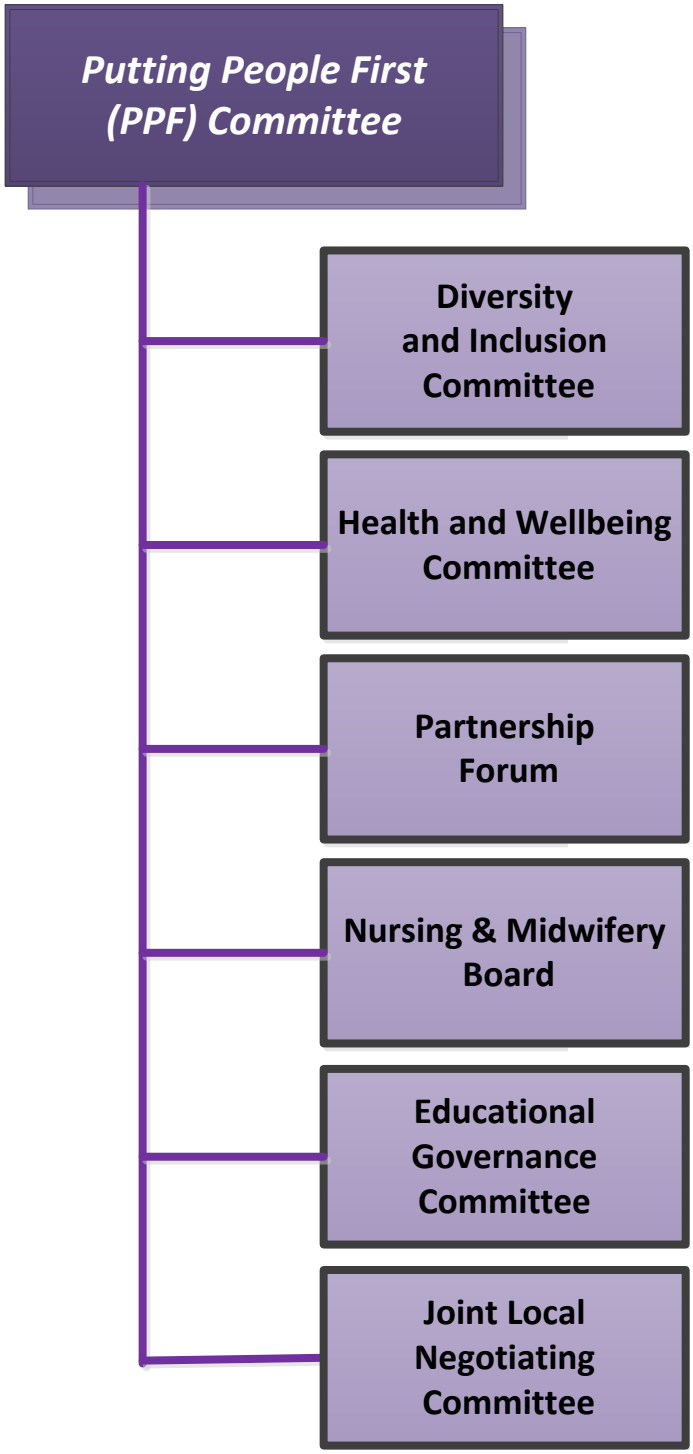
4. **New risks identified/action taken/escalation to BAF**

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


Putting People First (PPF) Committee
Diversity and Inclusion Committee
Health and Wellbeing Committee
Partnership Forum
Nursing & Midwifery Board
Educational Governance Committee
Joint Local Negotiating Committee

Liverpool Women's NHS Foundation Trust

Liverpool Women's NHS Foundation Trust

Putting People First Committee Annual Report 2017/18

Putting People First Committee

The aim of the Putting People First Committee is to develop and oversee the implementation of the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy) providing assurance to the Board of Directors that this is achieving the outcomes sought and required by the organisation. The terms of Reference of the Committee were reviewed in April 2017 and are as follows:

In discharging these duties the Committee is responsible for:

a. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process
b. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee)
c. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce
d. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors
e. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues
f. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys
g. Reviewing and approving partnership agreements with staff side
h. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues, including but not limited to equality and diversity
i. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings
j. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required.
k. Receiving and considering issues from other Committees when appropriate and taking any necessary action.

This remit is achieved firstly, through the Committee being appropriately constituted, and secondly, by the Committee being effective in ensuring internal accountability for implementation of the strategy through appropriate assurance mechanisms.

This report outlines how the Committee has complied with the duties delegated by the Trust Board through its terms of reference.

Constitution

The Committee membership (as appointed by the Board of Directors) comprises:

- Non-Executive Director (Chair)
- 2 other Non-Executive Directors
- Director of Workforce & Marketing
- Director of Nursing & Midwifery
- Director of Operations / General Manager
- Staff Side Chair
- Medical Staff Committee representative
- Representative from the Nursing & Midwifery Board
- Senior Finance Manager

In addition the Committee was supported by senior HR and OD staff, Chair of Education Governance Committee, with other officers attending as required.

Members can participate in meetings in person or 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

This is a sub-committee of the Board of Directors established to ensure effective implementation of the integrated workforce and organisational development strategy.

Five meetings were held during the financial year 2017/18. An attendance sheet is attached for information at the end of this report. The Committee was quorate for all meetings.

The Chair provides a chairs report into the Board of Directors after every meeting.

Achievements

The Committee's primary focus throughout the year was on the effective implementation of the year 3 goals of the People Strategy. The Committee also focused on the key Board Assurance Framework risks remitted to the Committee for oversight, review and update. These included:

- The risks associated with not having a well-led, engaged, motivated and effective workforce
- The risks associated with not having a Fully Resourced, Competent & Capable Junior Medical Workforce

In 2017/18, the Committee also;

- Agreed its Risk Appetite Statement for relevant risks
- Undertook a deep dive and gained assurance with respect to workforce risks in Maternity, Genetics, Hewitt Fertility, Gynaecology, Corporate, Neonates and Theatres. Staff Stories were also received for each of these areas.
- Monitored all workforce related Key Performance Indicators
- Gained assurance around the processes to deliver and monitor compliance with mandatory training requirements.
- Considered the Annual Staff Survey results and subsequent action plan
- Received an overview of Health Education England's Draft Health and Care Workforce Strategy for England to 2027
- Gained assurance to the safe working practices of the junior doctor workforce from the Guardian of Safe Working
- Received information relating to the key workforce risks and mitigations including succession plans for key specialist roles and plans to bridge the increasing national shortage of junior doctor numbers
- Gained assurance that there were no trends of concern with respect to the Trust's Disciplinary, Whistleblowing and Grievance processes

- Gained assurance that appropriate progress was being made in line with the Health & Wellbeing Strategy
- Received bi-annual updates on seven day services
- Regularly reviewed the progress made against the Equality Delivery System Goals & WRES and selected the areas for focus for improvement for 2017/18 and identified the areas for improvement within the Trust and remitted the actions to the Diversity & Inclusion Committee
- Received the Workforce Profile Report and identified areas for further action with specific regard to the employment of those with a disability
- Received updates on the Fit for Future Generations programme and oversaw workforce related cost improvement schemes
- Gained assurance of successful contract management of outsourced Payroll and Occupational Health services and received an update of the outsourcing of the recruitment service
- Ratified policies to ensure the HR policy schedule was in date
- Received regular Director of Workforce and Marketing reports
- Reviewed the findings of the following internal audit reports: Secondary Employment & Sickness Absence; Consultant Job Planning
- Regular update on the progress of the implementation of the Apprenticeship Levy and the implications for the Trust
- Reviewed the Settlement Agreements entered into by the Trust
- Reviewed the Volunteer Strategy and progress against its aims
- Reviewed the Communications & Engagement Strategy and progress against its aims
- Reviewed progress against the Nursing & Midwifery Strategy and safe staffing reports
- Regular updates on the implementation of the Talent Management programme and future developments
- Regular updates on the evaluation of the Leadership programme

The Committee reviewed and approved the following policies;

- Establishment Control SOP
- Retirement Policy & Procedure
- Policy for the Prevention & Management of Work Related Stress
- Job Matching & Evaluation Policy & Procedure
- E-Rostering Policy
- Annual Leave Policy
- Medical Appraisal & Revalidation Policy
- Remediation Policy
- Exception Reporting Policy
- Recruitment & Selection Policy
- Volunteer Policy
- Secondary Employment Policy
- Attendance Management Policy
- Grievance Policy
- Overpayments, Underpayment & Incorrect Payments Policy
- Study Leave Policy
- Work Experience Policy
- Expenses Policy
- Performance Development Review Policy
- Policy for Managing Conflicts of Interest
- Temporary Working Policy

The Committee received chair reports from the following reporting Committees:

- Partnership Forum
- Joint Local Negotiating Committee

- Education Governance Committee
- Diversity & Inclusion Committee
- Nursing & Midwifery Board
- Health and Wellbeing Board

Work planned for 2018-19

In 2018/19 the Committee will develop and ratify the new five year People Strategy.

The Committee will continue to strengthen its assurance approach by undertaking service 'deep dives' requiring leaders of the Trust's clinical and corporate services to present their key workforce risks and provide assurance to the Committee that these risks are appropriately identified, mitigated for and actively managed.

The Committee will continue to analyse trend data arising from the monthly KPI data and workforce planning reviews and again identify and mitigate any risks.

The Committee will meet five times per year and additional meetings will be arranged if necessary. The main functions of the Committee remain the same as the previous year in:

1) Ensuring appropriate levels of assurance are provided to the Board of Directors in relation to key risks relating to the workforce as identified in the Board Assurance Framework

2) Overseeing implementation of the Putting People First Strategy.

The Committee will continue to focus on ensuring relevant assurance on key risks identified within the Board Assurance framework.

Putting People First Committee Chair
April 2018

Putting People First Committee Attendance 2017/18

Committee Member		28 April 2017	23 June 2017	22 Sept 2017	24 Nov 2017	26 Jan 2018	% attendance
Tony Okotie (Committee Chair)	Non-executive director	✓	✓	AP	✓	✓	80
David Astley	Non-executive director	✓	✓	✓ Committee Chair	✓	✓	100
Ian Knight	Non-executive director	✓	✓	✓	✓	✓	100
Michelle Turner	Director of Workforce and Marketing	✓	✓	✓	✓	AP	80
Doug Charlton	Director of Nursing & Midwife	✓	✓	✓	AP	NM	80
Julie King	Acting Director of Nursing & Midwifery as of Dec 2017	NM				✓	
Jeff Johnston	Director of Operations	AP	✓	✓	✓	✓	80
Mark Clement-Jones	Medical Staff Committee Representative	AP	AP	NM			40
Lynn Greenhalgh	Medical Staff Committee Representative	NM		✓	✓	AP	
Liz Collins	Staff Side Chair		AP	AP	✓	✓	40
Claire Scott	Divisional Accountant	AP	✓	✓	✓	AP	60
In regular attendance as per its terms of reference							
David Dodgson	On behalf of divisional accountant	✓				✓	
Susan Westbury	Deputy Director of Workforce	✓	AP	AP	✓	✓	
Neil Rodgers	General Manager Operations	✓		✓	✓	✓	
Cath Barton	General Manager		✓				
Ruben Trochez	Education Governance Committee Chair	AP	AP	NM			

Linda Watkins	Education Governance Committee Chair	**NM**		✓	**AP**	✓	
Jean Annan	Head of Learning / Health and Wellbeing Manager	✓	✓	✓	✓	✓	
Rachel London	Head of Operational HR	✓	✓	✓	✓	✓	
Meeting Support							
Louise Hope	Assistant Trust Secretary		✓	✓	✓	✓	

✓ = In Attendance AP = Apologies Given x = Non Attendance NM = Non Member

Other Invited Attendees during 2017/18 are listed below:

Carla Marshall	HR Business Partner
Jackie Thomas	Occupational Health Manager
Rochelle Collins	Medical Staffing Advisor
Andrew Loughney	Medical Director
Gina Barr	Voluntary Services Manager
Gill Walker	Matron Gynaecology
Helen Christophorou	Midwife
Nikki Maggs	Theatres Manager
Steve Chokr	Deputy CIO
Lauren Shaw	Practice Education Facilitator
Emily Baker	Clinical Embryologist
Marion James	Nurse, Bedford Ward
Simon Davies	HR Advisor
Geoff Shaw	Guardian of Safe Working Hours
Chris McGhee	Freedom to Speak Up Guardian
Joanne Topping	Associate Medical Director for Revalidation
Kathy Smith	Medical Education Manager
Fiona Bryant	Acting Head of Midwifery as of April 2017
Ed Djabatey	Clinical Director for Anaesthetics
Jenny Brereton	Finance Assistant
James Roberts	Lead Clinical Coder, IMT
Mark Little	Staff Side Secretary
Rachel Gregoire	Scientific Director

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 23 April 2018

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

2. **Agenda items covered**
   - ~ **Operational Performance Month 12 2017/18 including RTT and Cancer Targets:** The Committee received Month 12 performance dashboard. As per last month's action the national performance data was identified 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%.
     The Committee noted that after partial validation of 18 weeks RTT, performance is expected to be 86% against a plan of 84%. The Committee was provided with an action plan and trajectory to compliance against the cancer targets. An emerging risk was highlighted with regards to the cancer 2 week rule target due to an increase of referrals during February and March 2018. The cause of the increase is unknown. The Committee was advised that work is underway to align capacity to meet spikes in demand.
   - ~ **Finance Performance Review Month 12 2017/18:** The Committee received Month 12 2017/18 finance position. It was noted that the Trust had been successful in receiving £2m STF incentive funding for 2018/19 which improves the year end deficit previously reported. The closing deficit was £1.3m after receipt of £5.5m in STF. The Committee were informed that the Trust ended the year well within the agency cap set by NHSI. The Committee also noted the year end cash balance position of £6m compared to £4.9m the prior year. It was also reported that repayment of the Interim revenue loan from 2015/16 has been extended to March 2019 from March 2018. Due to final adjustments the Committee would receive an updated financial performance pack ahead of the Board meeting in May. The Committee formally thanked the Finance Department for achieving the end of year performance.
   - ~ **Financial and Operational Plan Update 2018/19:** The Committee noted that NHS Improvement (NHSI) had set a control total which is supportive of the clinical case for change, this would require formal approval by the Board of Directors ahead of the submission of the final plan on 30 April 2018.
   - ~ **Treasury Management Quarterly Report:** The Committee noted the Treasury Management position at year end including cash flow, loans and age of debt.
   - ~ **Strategic Outline Case updates:** The Committee received a status update.
   - ~ **Cost Improvement Programme Update 2018/19:** The Committee received a progress update against the 2018/19 CIP schemes including quality impact assessments and Equality impact assessments signed off by the Medical Director and the Acting Director of Nursing and Midwifery.
   - ~ **Electronic Patient Records (EPR) Update:** The Committee noted continued work to manage and deliver the EPR programme. It was noted that the supplier is continuing to work with the project team to resolve issues however risks remain with some modules. It had been recommended that the Board of Directors receive a monthly update of programme delivery as of May 2018.
     The Committee challenged the lack of NED engagement with the programme board which was agreed as part of the governance process and asked the Chief Information Officer to escalate to the Programme Board.
   - ~ **Information Governance (IG) Update:** The Committee noted that the Trust had achieved 75% in the 2017/18 IG Toolkit assessment and received an audit opinion of significant assurance against the IG Toolkit submission.
   - ~ **Neonatal Redevelopment Project:** The Committee noted the project progress, the proposed governance structure and the terms of reference for the Neonatal Redevelopment Project Board.

NHS

The terms of reference were approved subject to the addition of an IT representative to be added as an invited member.

- **Neonatal Single Service Update:** The Committee noted the successful progress to date.
- **Genetics Tender:** The Committee noted the regional position of the genetics service going forward.
- **Liverpool Women's Health Consultancy Business Development Update:** The Committee received a detailed position update.
- **FPBD Committee Annual Report:** The Committee approved the annual report and would submit to the Board of Directors in May 2018.
- **Sub Committee Chairs reports received**
  - Turnaround and Transformation Committee held 16 April 2018
  - Emergency Planning Resilience and Response Committee held 9 April 2018
  - Information Governance Committee held 23 March 2018
  - Digital Hospital Sub-Committee none held

  The Committee noted and approved the above Chairs reports of its reporting sub-committees.

3. Board Assurance Framework (BAF) risks reviewed

- The Committee reviewed the BAF risks it is responsible for on behalf of the Board and recommended a reduction of the current risk score for BAF risk 2168 - to deliver the annual financial plan from 15 to 10. Likelihood 2 x Impact 5 due to delivery outcomes being achieved.

  The Committee considered the risk score position for 2018/19 and agreed the following:
  Risk 2168 – current risk score for 2018/19 to be increased to 25, Target risk score to remain as 10
  Risk 1986 – Current risk score to remain as 25, Target risk score to remain as 25

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. The Committee wishes to note the emerging risk identified with regards to the cancer 2 week rule target due to an increase of referrals during February and March 2018.

5. Issues to highlight to Board

- EPR Programme delivery risks: The Committee highlights increasing concerns relating to delivery of the EPR programme against the agreed timescales and supports additional reporting of EPR delivery to the Board of Directors.

6. Action required by Board

- NHSI Control Total: The Committee wishes to highlight the control total set by NHSI and requests consideration and approval to be sought from the Board of Directors.

- To approve the Finance, Performance and Business Development Committee Annual Report 2017/18 (enclosed)

Jo Moore
Chair of FPBD

Liverpool Women's NHS Foundation Trust

Finance, Performance & Business Development Committee Annual Report 2017/18

The Finance, Performance & Business Development Committee

The Committee is responsible for reviewing the Trust's financial strategy, performance and business development.

It completes these responsibilities as follows;

Finance and performance

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

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.
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

This remit is achieved through the Committee being appropriately constituted, and by the Committee being effective in ensuring internal accountability and the delivery of assurance services.

This report outlines how the Committee has complied with the duties delegated by the Trust Board through the terms of reference.

Constitution

The Finance, Performance and Business Development Committee is accountable to the Board of Directors.

Membership during the year comprised;

- Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- Chief Executive
- Director of Finance
- Director of Operations

Meetings were also attended by other senior management staff as appropriate.

The Committee met in accordance with the frequency laid out in its terms of reference which is at least five times per year. The Terms of Reference were reviewed in March 2017 in preparation for 2017/18 committee business and were reviewed again in March 2018 in preparation for 2018/19.

Eleven meetings were held during the financial year 2017/18 to reflect the financial challenges faced by the Trust. Members participated by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference.

Key Achievements

Significant financial and strategic matters were adequately discussed with appropriate regard to risk, generating appropriate actions which were followed up on a timely basis. Key achievements are noted below:

Finance and Performance reporting
The Committee reviewed the detail of the financial and operational plans for 2017-19 in March 2017 and recommend approval of the plans to the Board in April 17. During the 2017/18 financial year the Committee received monthly oversight of the plans noting remedial actions where appropriate.

The Committee supported the receipt of STF Incentive funding through delivery of an improved control total in 2017/18.

The Committee also reviewed the detailed draft update to the financial and operational plan for 2018/19 ahead of final submission in April 18.

The Committee received monthly performance metrics and a formal briefing on a cancer target reporting incident in February 2018. It escalated the matter for the Board of Directors attention and continues to receive a monthly position update.

The Committee also requested quarterly detailed treasury reporting updates which began for Q3 of the financial year.

NHS Improvement (NHSI) Reporting and Distressed Finance Funding
The Committee noted monthly financial submissions to NHS Improvement (NHSI) as part of the monthly finance submissions and noted the cash draw down requirements within these.

Monitoring the Trust CIP programme
The Committee received and reviewed on a regular basis the Trust's progress against its challenging CIP targets for 2017/18.

The Committee reviewed and challenged the financial targets of each scheme as well as receiving assurance that the Quality Impact Assessments behind each one had been approved by the Medical Director and Director of Nursing and Midwifery.

The Committee has also reviewed the mid-year CIP post implementation review and governance processes in place around the delivery of CIP.

The Committee received updates from the Turnaround and Transformation Committee in relation to the identification of CIP schemes for 2017/18 and 2018/19 and regularly received the Chairs reports from the Turnaround and Transformation Committee.

MARS Scheme
The Committee approved the introduction of the MARS scheme during 2017/18, which was open for applications in March 2018.

Strategic Options
The Committee supported the Strategic Options business case and monitored the consultation process led by the Liverpool Clinical Commissioning Group.

The Committee supported the Strategic Outline Case (SOC) in August 2017 and received Board approval on 1 September 2017. It was noted that the SOC has been referred to the Northern NHS England Team to review ahead of public consultation.

Neonatal Business Case
The Committee supported the development of a £15m Neonatal Business Case to refurbish the Neonatal Unit and noted the Department of Health approved loan to support the build project. The Committee monitored progress to date with the capital build award.

IM&T strategy
The Committee have monitored the progress of the implementation of the IM&T Strategy receiving regular detailed updates from the Chief Information Officer. Notably the Committee has considered detailed reports relating to the implementation of the Electronic Patient Record (EPR) business case, Global Digital Exemplar Fast Follower application and General Data Protection Regulations. The Committee also received a debrief paper with regards to a national cyber-attack incident and the Trust's IM&T infrastructure resilience.

The Committee received regular updates from the Digital Hospital Committee in the form of a Chairs report.

Hewitt Fertility Centre (HFC)
The Committee received regular updates regarding the future delivery model for the Hewitt Fertility Centre services, challenging performance against the financial plan. The Committee was satisfied by the month on month improved position and tighter management control and agreed in October 2017 to discontinue the formal briefings on this area and receive updates within the monthly financial and operational performance reports.

International Developments
The Committee received regular overviews of strategic business developments and made recommendations to the Board in relation to future opportunities.

Business Assurance Framework (BAF)
The Committee reviewed the Board Assurance Framework risks assigned in line with the business cycle of activities. The Committee have held discussions over the rating of specific risks and amended the BAF accordingly. It also approved the Risk Appetite Statement in April 2017 for 2017/18 and in March 2018 for 2018/19.

Emergency Preparedness, Resilience and Response (EPRR)
The Committee received the annual EPPR report noting assurance of compliance against the NHS EPRR core standards. It also received progress updates against fire safety requirements as a result of the national fire incident.

Marketing Strategy
The Committee received assurance of progress being made against the Communications, Marketing and Engagement Strategy 2016/20 in January 2018.

Conclusion

In evaluating its achievements it is concluded that the Finance, Performance & Business Development has achieved its objectives for the Financial Year 2017/18.

Work planned for 2018-19

- Review developments in terms of the Trust Strategic Outline Case and associated consultation
- Consider the impact of the Trust's financial position on the wider organisation and NHSI undertakings
- Review progress against key financial and performance targets, including CIP
- Review performance against the operational plan
- Monitor progress to recover the cancer target and referral to treatment target position
- Monitor progress and governance of the Neonatal Capital Build
- Continue to monitor all international business developments
- Continue to oversee the EPR project and monitor risks associated with delivery
- Approve the 2019/20 operational plan
- Regular review of BAF risks assigned to the Committee

Finance, Performance & Business Development Committee Chair
April 2018

Finance, Performance & Business Development Committee Attendance 2017/18

MEMBERS	JOB TITLE	April 2017	May 2017	June 2017	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	%
Jo Moore	CHAIR Non-Executive	✓	✓	✓	✓	✓	✓	✓	AP		✓	✓	✓	
Ian Haythornthwaite	Non-Executive	✓	✓	✓	✓	✓	✓	AP	✓		✓	✓	✓	
Phil Huggon	Non-Executive	AP	✓	✓	AP	✓	✓	AP	✓		✓	✓	✓	
Vanessa Harris	Director of Finance	✓	✓	AP	✓	✓	AP	✓	✓		✓	NM		
Jenny Hannon	Director of Finance (as of Feb 2018)											✓	✓	
Kathryn Thomson	Chief Executive Officer	AP	AP	✓	✓	✓	AP	AP	AP		AP	AP	✓	
Jeff Johnston	Director of Operations	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	
Attendance to ensure committee quorum														
Ian Knight	Non-Executive							✓			✓	✓	✓	
Robert Clarke	Chair			✓				✓			✓	✓		
In regular attendance as per terms of reference														
Jenny Hannon	Deputy Director of Finance / Director of Strategy &Planning as of 1 Oct 2017	✓	✓	✓	✓	AP	✓	✓	✓		✓			
Janet Parker	Acting Deputy Director of Finance as of 1 Oct 2017							✓	✓		✓	✓	✓	
Meeting Support														
Louise Hope	Assistant Trust Secretary	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	

✓ = In Attendance AP = Apologies Given x = Non Attendance NM = Non Member

Other Attendees invited to the meeting during 2017/18 are listed below:

David Walliker,	Chief Information Officer	Jonathan Lofthouse,	Transformation Director
Neil Rogers,	Managing Director Hewitt Centre	Gregory Hope,	Head of Governance
Steve Chokr,	Deputy Chief Information Officer	Andy Large,	Head of Finance
Andrew Duggan,	Head of Communications & Marketing	Vicky McKay,	Clinical Transformation Lead

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Quality Committee meeting held 23 April 2018

1. Was the quorate met? Yes

2. Agenda items covered

~ Subcommittee Chairs reports:
  - Corporate Risk Committee held 16 March 2018
  - Experience Senate held 10 April 2018
  - Effectiveness Senate held 16 March 2018
  - Safety Senate held 9 March and 13 April 2018
  - Hospital Safeguarding Board held 20 March 2018

The Committee noted and approved the above Chairs reports of its reporting sub-committees.

~ Annual Review of Mortality Strategies: The Committee noted progress made against the adult mortality strategy and the perinatal mortality strategy. It was noted that a sepsis lead had been appointed which has improved the monitoring of sepsis information. It was also noted that the policies and guidelines are difficult to maintain due to cross ownership across teams. No outstanding risks were identified. It was highlighted that the CQC inspectors had commended the Honeysuckle (Bereavement) Team during the recent inspection.

~ Draft Annual Quality Report 2017/18: The Committee considered the draft annual quality report 2017/18 and provided comments to be verified within the report. The report will be presented to the Clinical Commissioning Group on 4 May 2018 and to Audit Committee and the Board of Directors on 18 May 2018 for final approval prior to submission to NHS Improvement (NHSI) on 29 May 2018. The Committee was advised that the External Auditors have confirmed that they would be satisfied for the Trust to enclose the last two months of cancer 18 weeks and RTT data reporting and would require assurance against the other targets.

~ Quarterly Review of Quality Strategy, Quarter 4 2017/18: The Committee considered the quarterly review of the Quality Strategy. There was a discussion with regards to the accountable officers for delivery against the quality strategy and it was agreed to consider further at Executive Committee. It was noted that the Committee would receive a revised format of this report for quarter 1 2018/19.

~ Quality and Regulatory Improvement Requirements: The Committee noted that the Care Quality Commission (CQC) draft inspection report had been received. The Executive Team are preparing an accuracy check submission to be submitted by 26 April 2018. It is expected that the CQC will publish the report within 3 weeks.

~ Serious Incidents and Learning reports, Quarter 4 2017/18: The Committee received a revised format detailing serious incidents by quarter rather than monthly information. The Committee agreed to receive a summary update of serious incidents (SIs) and was assured that the Safety Senate considers each serious incident in detail; however any themes or concerns must be escalated to the Committee. It was noted that a new system to record SIs is being proposed and developed by NHSI.

~ Quality Committee Performance Dashboard Report – Month 12: The Committee received Month 12 performance dashboard. The Committee noted that after partial validation of 18 weeks RTT, performance is expected to be 86% against a plan of 84%. An emerging risk was highlighted with regards to the cancer 2 week rule target due to an increase of referrals during February and March 2018. The cause of the increase is unknown and could be due to recent media attention or GPs using the rules to achieve quicker patient access. The Committee was advised that work is underway to align capacity to meet spikes in demand. It was confirmed that the CCG and

NHS

Cheshire and Merseyside Cancer Alliance are not currently concerned about this target as the number of patients is very few however from a Trust perspective the Committee is concerned about patient experience caused by capacity issues.

~ **Elective Access Policy:** The Committee reviewed and approved the Elective Access Policy.

~ **Quality Committee Annual Report 2017/18:** The Committee approved the annual report and would submit to the Board of Directors in May 2018.

3. Board Assurance Framework (BAF) risks reviewed

The Committee reviewed the quality related BAF risks it is responsible for on behalf of the Board and recommended no change to the risk scores for 2017/18. They noted the necessity to ensure that the action plan, timescales and sources of assurance columns are kept regularly updated.

The Committee also considered the risk score positions for 2018/19 and agreed the following:

Risk 1986 No change to position. Current risk score 20, Target risk score 20

Risk 1742 No change to position. Current risk score 12, target risk score 6

Risk 1739 No change to position. Current risk score 12, Target risk score 8

Risk 2184 Committee considered the risk score and whether a reduction in the target risk score should be made given implementation due in October 2018. The Executive Committee was asked to review.

Risk 2168 Current risk score 12 to remain. It was recommended to increase the Target risk score as unlikely to be reduced within 12 months. (L) 3 x (I) 4 = 12

Risk 2167 Committee considered the requirement to maintain this risk on the BAF as objectives are being achieved. Executive Committee to review.

4. Escalation report to the Board on Quality Committee Performance Measures

See section 2, within Quality Key Performance Indicator Report Month 12.

5. Issues to highlight to Board

~ None

6. Action required by Board

~ To approve the Quality Committee Annual Report 2017/18 (enclosure)

Susan Milner
Chair of Quality Committee

Quality Committee Annual Report 2017-18
(previously Governance and Clinical Assurance Committee)

Quality Committee

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

It completes these responsibilities as follows:

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) 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.
i) Obtain assurance that the Trust is compliant with guidance from NICE (through receipt of an Annual Report) and other related bodies.
j) 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.
k) 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.
l) 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;
m) Undertake an annual review of the Quality and Risk Management Strategies to ensure that they reflect all required priorities;
n) To have oversight of the Committees performance measures to ensure they are appropriate and provide assurance of compliance and escalate exceptions to Trust Board.
o) To review the proposed internal audit plan for all functions areas within the Committees remit e.g. Clinical Audit, Safety, Experience and Effectiveness.

p) Review the Trust's Research and Development Strategy and Innovation Strategy prior to their recommendation it to the Board of Directors
q) Approving the terms of reference and memberships of its subordinate committees
r) 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.
s) Referring relevant matters for consideration to other Board Committees as appropriate.

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

Constitution

The Quality Committee is accountable to the Board of Directors. Membership during the year comprised:

- 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

Meetings were also attended by other senior management staff as appropriate. Seven meetings were held during the financial year 2017-18. This is in accordance with the frequency laid out in its terms of reference. As of January 2018 it was agreed that the Committee shall hold meetings monthly and its terms of reference was amended.

*denotes: or their nominated representative who will be sufficiently senior and have the authority to make decisions.

Key Achievements

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

Committee Review

The Committee held an efficiency review workshop facilitated by Mersey Internal Audit Agency to consider the efficiency and purpose of the Committee as the Trust moves forward the Future Generations Clinical Strategy. The Committee noted the recommendations and requested Board of Director approval to change the Committee name, revise the terms of reference and work plan, and increase the frequency of meetings to monthly.

Board Assurance Framework (BAF)

The Committee reviewed those risks assigned to it on the BAF at each of its meetings. It also approved the Risk Appetite Statement in May 2017 and March 2018.

Quality Strategy

The Quality Strategy, in conjunction with the BAF and Risk Management Strategy, form the foundation of the Quality Governance requirements of the Trust. The Committee reviewed and approved the Quality Strategy 2017-20. The Quality Strategy was approved by the Board on 2 June 2017.

Quality Report
The Committee approved the Quality Report 2016-17 and recommended formal approval of the Board of Directors on 19 May 2017.

Mortality Strategies
The Committee following authority received from the Board of Directors noted the amendments made to the strategies requested by the Board and approved the Adult Mortality Strategy and Perinatal Mortality Strategy. Alongside an annual review of both strategies the Committee is receiving further assurance from quarterly mortality reports and also receives an annual stillbirth report.

Clinical Assurance and Performance
A revised clinical performance dashboard comprising of indicators specific to this Committee's responsibilities was received and approved. The Committee continued to receive a monthly update.

Complaints, Litigation, Incidents & PALS
The Committee routinely considered the Trust's Safety, Effectiveness & Experience (SEE) report. This contained information on the full spectrum of Governance activity but gave the Committee particular assurance regarding the handling of complaints, litigation, incidents and Patient Advice and Liaison Service contacts. It also received regular serious incident update reports and an aggregated review of incidents as additional assurance of the process undertaken to manage serious incidents within the Trust. The Committee is due to receive an updated SEE report in May 2018.

Verita Recommendations Close out action plan
The Committee received a retrospective review of the Verita report recommendation action plan. This was a remitted action from the Board of Directors to assess the Trust's compliance with the external assessment commissioned in relation to the Trusts governance processes. The review confirmed the Trust has maintained compliance with recommendations.

Care Quality Commission
The Committee received regular reports detailing the Trust's position against the CQC's fundamental standards and noted the findings of two unannounced internal audit inspections within Gynaecology and Maternity. It also noted the CQC unannounced inspection visit in January 2018 and the well-led inspection visit in February 2018. The Committee also reviewed and approved the CQC Statement of Purpose in March 2018.

Clinical Audit
The Committee received and noted assurances in the Clinical audit forward plan which provided assurance in respect of the Trust's programme of clinical audit and the level of engagement. The number of audits undertaken is being managed to fit resources and ensure timely completion.

Equality and Human Rights
The Committee received a progress review of Equality and Human Rights Goals 1&2 and considered their role in evidencing outcomes which were directly related to members of the Committee and other senior leaders and Board directors in the Trust.

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

Infection Prevention and Control
The Committee received an annual report in respect of the Trust's infection prevention and control performance and also the arrangements in place to support the achievement of low rates of MRSA and Clostridium difficile infections.

Research and Development
The Committee received the annual report detailing the Trust's research and development activities and supported the development of a Research and Innovation Strategy. The Research and Innovation Strategy is due to return to the Committee for formal sign off at its April 2018 meeting.

Health and Safety
The Committee reviewed the annual report and monitored progress against the health and safety self-assessment gap analysis.

Conclusion

In evaluating its achievements it is concluded that the Quality Committee has achieved its objectives for the Financial Year 2017/18.

Work planned for 2018-19

- To monitor progress quarterly of the Quality Strategy for 2017-20;
- To review and recommend to the Board of Directors the 2017-18 Quality Report;
- To consider the impact of the Trust's financial position on quality of safe clinical services;
- Review and scrutinise the risks assigned to the Committee in the BAF and agree annual risk appetite statement;
- Review lesson learnt and trends from Serious Incident reports, clinical performance reports;
- Review assurances that the Trust has in place effective governance systems, risk management and quality improvement arrangements and identifying key concerns for the attention of the Board of Directors.
- Receive assurance from the Safety, Experience and Effectiveness Senates as to progression of work plans and escalation of risks and issues.
- To review and consider the Committees Terms of Reference.

Quality Committee
April 2018

Committee Member	Job Title	May 15 2017	July 17 2017	Sept 18 2017	Nov 20 2017	Jan 15 2018	19 Feb 2018	19 March 2018	% attendance
Susan Milner (Chair)	Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	**100**
David Astley	Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	**100**
Phil Huggon	Non-Executive Director	✓	✓	✓	**AP**	✓	✓	✓	**85**
Doug Charlton	Director of Nursing & Midwifery	✓	✓	✓	**AP**	**NM**			**75**
Julie King	Deputy Director of Nursing & Midwifery Acting Director of Nursing & Midwifery (as of Dec 2017)	✓	**AP**	✓	**AP**	✓	✓	✓	**70**
Jeff Johnston	Director of Operations	✓	✓	✓	✓	✓	✓	✓	**100**
Andrew Loughney	Medical Director	✓	✓	✓	✓	✓	✓	✓	**100**
Vanessa Harris	Director of Finance	✓	✓	**AP**	✓	✓	**NM**		**80**
Jenny Hannon	Director of Finance						✓	✓	**100**
Michelle Turner	Director of Workforce & Marketing	✓	✓	**AP**	✓	**AP**	✓	**AP**	**57**
Christopher Lube	Head of Governance	**NM**				**AP**	✓	✓	**67**
Gregory Hope	Head of Governance	✓	**AP**	✓	**NM**				**67**
Clare Fitzpatrick	Acting Deputy Director of Nursing and Midwifery (as of Dec 2017)	**NM**				✓	✓	✓	**100**
In regular attendance as per terms of reference									
Colin Reid	Trust Secretary	✓	✓	✓	✓	✓	✓	✓	
Meeting Support									
Louise Hope	Assistant Trust Secretary		✓	✓	✓	✓	✓		

✓ = Attendance **AP = Apologies Given** **x = Non Attendance** **NM = Non Member***or their nominated representative who will be sufficiently senior and have the authority to make decisions

Other Invited Attendees during 2017/18 are listed below:

Jenny Hannon	Deputy Director of Finance	Tony Okotie	Non-Executive Director
Rachel London	Acting Deputy Director of Workforce	Kathryn Thomson	Chief Executive
Amanda McDonough	Head of Safeguarding	Louise Hardman	Research & Development Manager
Mark Turner	Director of Research & Development	Michelle Morgan	Head of Audit, Effectiveness & Experience
Alan Clark	Patient Safety Programme Manager	Kevin Robinson	Deputy Head of Patient Experience

Chris McGhee	Head of Nursing & Operations	Tracy Bryning	Health & Safety Manager
Ian Hinitt	Interim Associate Director of Estates & Facilities	Linda Martin	Patient Facilities Manager
Mr Tim Crowley	Mersey Internal Audit Agency	Heather Watterson	Governance Co-ordinator
Vicky Murphy	Paralegal	Gill Diskin	Maternity Matron
Susan Westbury	Deputy Director of Workforce		

Agenda Item	2018/126

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Whistleblowing and Speak Up Guardian Annual Report**
DATE OF MEETING:	Friday, 04 May 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Michelle Turner, Director of Workforce and Marketing
AUTHOR(S):	Chris McGhee – Freedom To Speak Up Guardian
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☐ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☐ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS*** ☒

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution **2.** Operational Plan **3.** NHS Compliance	☒ ☒ ☒	**4.** NHS Constitution **5.** Equality and Diversity ***6.*** Other: **Click here to enter text.**	☐ ☒
FREEDOM OF INFORMATION (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 accept the assurance provided by this report and endorse the further actions proposed.			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Putting People First Committee	
	Date of meeting		Friday, 20 April 2018	

Executive Summary

This is the annual report completed by the Freedom To Speak Up Guardian to provide the committee with assurance regarding Whistleblowing. It includes details of those issues that have been formally raised with the Trust and how they have been dealt with.

Report

1. Introduction

The Trust is committed to developing and maintaining an open and constructive culture whereby all staff feel comfortable in raising any concerns they might have regarding the Trust and the services that it provides. All staff should feel able to raise concerns in the knowledge that they will be taken seriously, that their concerns will be addressed, and without any fear of reprisal of detriment. While this commitment is based in, and underpinned by our statutory and legal obligations, the Trust's Whistleblowing Policy & Procedure encapsulates it in a form that is easily accessible for all staff.

This report is produced on an annual basis to give the committee assurance that the policy is in place, and that it is both appropriate and regularly updated. It also provides a summary of whistleblowing cases over the previous twelve months to further provide assurance that the policy is being appropriately implemented.

2. Issues for Consideration

2.1. Trust Policy

The Trust's policy was updated in September 2017 with minor amendments to reflect the change of the Trust's auditors/anti-fraud specialists.

2.2. Assurance: Annual Staff Survey Results

The National NHS Staff Survey includes three questions that specifically relate to issues around raising concerns.

The results from the 2017 survey show some improvement from previous year's results. The percentage of staff who would feel secure raising concerns about unsafe clinical practice rose from 67% in 2016 to 72% in 2017. Similarly, the percentage of staff who are confident that their organisation would address their concerns rose from 59% in 2016 to 62% in 2017. As in the previous year, 97% of staff said that they knew how to report concerns about unsafe clinical practice.

Our 2017 results also compare favourably with those of other specialist acute Trusts nationally. These results demonstrate the fact that almost all staff know how to report a concern, and that the majority of staff feel secure in raising a concern, and confident that it will be addressed.

The table below shows the Trust's results from the 2017 survey, together with comparisons against the national comparator (in our case Acute Specialist Trusts) and the Trust's previous results:

Question		LWT 2017	Comparator 2017	LWT 2016	LWT 2015	LWT 2014
	Q13a If you were concerned about unsafe clinical practice, would you know how to report it ?					
Yes		97%	95%	97%	96%	94%
No		3%	5%	3%	4%	6%
	Q13b. I would feel secure raising concerns about unsafe clinical practice.					
Agree / Strongly Agree		72%	71%	67%	67%	66%
Disagree / Strongly Disagree		10%	9%	11%	11%	13%
Neither agree nor disagree		19%	20%	21%	21%	21%
	Q13c. I am confident that my organisation would address my concern.					
Agree / Strongly Agree		62%	63%	59%	61%	58%
Disagree / Strongly Disagree		11%	10%	11%	11%	12%
Neither agree nor disagree		27%	28%	30%	27%	30%

source: raw data for 2016 NHS Staff Survey supplied by Quality Health

2.3. Whistleblowing Declarations

In the previous twelve months there were seven formal whistleblowing concerns raised under the Trust's Whistleblowing Policy:

1) An anonymous concern alleged some irregularities/potential fraud with regards to overtime and bank work in the Ultrasound Department. This was investigated and no evidence of any fraud was found.

2) An anonymous concern was raised in relation to unsafe staffing levels in maternity, specifically around staff not being able to take their breaks and not being able to give the best standard of care to patients. An internal investigation was undertaken which identified a number of issues that

were fed into a wider review of staffing levels. This resulted in a specific action plan which included the recruitment of additional midwives.

3) An anonymous concern was raised alleging that the 2015 restructuring of the Governance Department had not been carried out in accordance with Trust policy, and also that the Trust was masking certain risks, thereby posing a risk to patient safety.

4) A further anonymous concern was received alleging that the way the Governance Department was managed was "non-inclusive" and "dictatorial".

Concerns 3) and 4) were jointly investigated. Some issues were identified and appropriate actions were put in place.

5) An anonymous concern was raised regarding staff on MLU using e-cigarettes. The Matron raised this issue at staff meetings and it was made clear to staff that this is not acceptable and that any staff caught using e-cigarettes in the Trust would be subject to disciplinary action.

6) An anonymous concern was raised alleging that cots on the neonatal Unit weren't being disinfected properly. The Head of Nursing & Operations for Neonates reviewed policy and practice and reinforced with staff the proper procedures for the disinfection of cots.

7) UNISON raised an issue on behalf of OCS security staff in relation to their staffing levels and the potential risk to patients and staff. Meetings have taken place with management from the Trust & OCS and with the local UNISON rep who had raised the issue, and although the matter was thought to have been resolved, it has now been escalated to the UNISON regional officer.

Feedback has been provided to UNISON on the concern they raised, but the other six concerns were raised anonymously so we were unable to feedback to those who raised the concerns.

There were two Employment Tribunals which had been raised by former employees which related in part to whistleblowing concerns that they had allegedly made while working for the Trust. Both these have now been heard at Tribunal. One was found in favour of the Trust, and we are just awaiting the outcome of the second one.

2.4. Freedom to Speak Up Guardian (F2SUG)

In the previous 12 months a total of 23 contacts were made to the Freedom to Speak Up Guardian requesting support to raise a concern in addition to these another 14 contacts were made requesting a safe space to talk through a work related issue – these are usually issues related to Grievance or interpersonal issues within teams where no action is required by the Guardian.

In the majority of cases the member of staff request anonymity and wanted the F2SUG (Freedom to Speak Up Guardian) to raise the matter on their behalf, stating that they felt that there would be repercussions if they raised it in their own name. Three members of staff were happy to raise in their own name, but requested support from the Guardian when raising the concern with a senior member of staff.

Concerns were raised by a range of staff representing a wide range of staff groups with Nurses and Midwives representing the main group for contact.

The Freedom to Speak up Guardian was absent due to sickness for a long period in Quarter 3, so interim arrangements were made with Liverpool Royal university Hospital Freedom to Speak up Guardian, this was communicated to staff via intranet bulletins, posters and screensaver messages. During this time only 1 contact was made to the external Guardian and this is now within the remit of the internal guardian as the staff member wanted the case to be supported by the internal Guardian.

Feedback to the Guardian is collected at the end of an episode of raising concerns with staff feedback being wholly positive, the only negatives (2 Respondents) seemed to be around the length of time taken to investigate concerns by Managers once they have been raised, the F2SUG is now developing a process to agree a timeframe with managers at the start of an investigation so that the staff member has an agreed timeframe for a response.

The F2SUG met with the CQC as part of the Well Led inspection in February 2018, and was questioned about how the role has been received by staff and senior managers within the Trust, the F2SUG was able to report no difficulties or barriers were in place in the Trust to raising concerns and that concerns raised by staff were listened to by senior managers and investigated appropriately.

CQC inspectors in an earlier meeting (Summer 2017) with the F2SUG raised the issue of cover for annual leave and sickness and also potential for conflict of interest if nurses wanted to raise concerns about the F2SUG in her day job as Head of Nursing for Gynaecology, in light of this the Trust accepted that a second F2SUG would be advantageous and set out to recruit a second Guardian.

The Guardian meets all new staff via Trust Induction sessions, Junior Doctor Inductions, Medical and Nursing Students induction sessions.

2.5. Other Developments

2.5.1. Appointment of a second Freedom to Speak Up Guardian

The Trust recently advertised for and appointed a second Freedom to Speak Up Guardian who will take up post shortly. This is to ensure that the role is accessible across the Trust to all staff. When the new guardian takes up their post, communications will be put in place to publicise their appointment, the role of the Freedom to Speak Up Guardian in general, and the work of the Dignity at Work Advisors.

2.6. Further Actions

Continue to meet with staff groups to publicise the role of the Freedom to Speak Up Guardian and the recruitment of a second Guardian, gain greater insight into why staff continue to feel unsafe to raise concerns in their own name.

Continue to work with Reginal and National Guardians to improve communication and standards of working and reporting of Concerns Raised.

More detailed analysis of the latest Staff Survey to identify pockets of concern and prioritise these areas for contact and support.

Develop (with HR) a training program for Managers about how to receive a concern, a good practice guide, their duties and responsibilities.

Work with regional BMA reps to identify barriers to medical staff raising concerns and strategies for building trust and engagement as currently no concerns have been raised by any medical staff in LWH.

Work with the Governance team to identify any trends and themes in concerns raised and cross reference these with incidents and complaints to see if there is a correlation.

3. Conclusion

This paper demonstrates that the Trust does have an appropriate policy in place and that it is regularly reviewed and updated to take account of both local and national developments.

It also provides assurance that any concerns that have been raised have been dealt with appropriately.

4. Recommendation(s)

The Board is asked to accept the assurance provided by this report and endorse the further actions proposed.

Agenda Item	**2018/127**

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Adult Mortality Report 17/18 Q4**
DATE OF MEETING:	Friday, 04 May 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Devender Roberts – Associate Medical Director Amanda Cringle – Quality Improvement Lead
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: **Quality Strategy & Quality Schedule**
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to: a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board b. Confirm that the Board are confident there are effective governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at this trust	
PREVIOUSLY CONSIDERED BY:	**Committee name**	*Choose an item.* Or type here if not on list: Effectiveness Senate
	Date of meeting	Friday, 04 May 2018

Executive Summary

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

This report details how the trust is meeting the requirements laid down externally and provides details of mortality within the Trust during Quarter 4 of 2017-18. It concludes that there is currently evidence available that adequate progress is being made and that mortality rates are within expected ranges. The report outlines the work taking place operationally and is being overseen by Quality Committee.

Report

Introduction

Liverpool Women's NHS Foundation Trust recognises that although most of the adult death it encounters is the expected end point of a known disease process, the principles described above are equally valid to its own services. In the Trust's Risk Management Strategy, commitment is given to minimise risk through the systematic embedding of relevant, efficient and effective risk management processes.

Issues for Consideration

- Each in-hospital death has a mortality review. All adult gynaecology deaths are discussed at the gynaecology Morbidity & Mortality meeting. As part of this process an adult mortality sheet is completed indicating any potential for improvement in care. Unexpected adult gynaecology deaths trigger a serious incident investigation.
- All direct maternal deaths trigger serious incident investigation.

- A new mortality review tool has been developed for risk and incident reporting system Ulysses. This avoids losing any paper documents (current system) and allows for searching, monitoring and auditing of an electronic system.

Adult Mortality Quarter 4		
	Maternity	**Gyneacology**
No of Adult Deaths	0	0
No of Mortality Reviews completed	0	0
No of deaths requiring RCA's	0	0
No of deaths due to deficiencies in care	0	0
Mortality Themes	N/A	N/A
Progress v Smart Plans	N/A	N/A
Mortality Outcomes	N/A	N/A
Measures for ongoing scrutiny	N/A	N/A

Actions Taken

Out of hospital deaths 2017-18 Quarters 1- 4

There were two maternal deaths reported externally via MBRRACE-UK national reporting system. Both were due to indirect causes: brain haemorrhage and leukaemia.

Work is now ongoing with other Trusts in developing an alert process of expected or unexpected deaths of patients who had previously been under the care of LWH. Aintree Hospital has already agreed an alert system.

The AMD and Governance team have put in a place a process for triangulating out of hospital deaths with the MBRRACE-UK midwives and the surrounding Trusts to get better ascertainment.

Table below depicts the number of adult deaths in-hospital, including expected and unexpected deaths.

Reporting Quarter	**2015-2016**		**2016-2017**		**2017-2018**	
	In-hospital	**Out-hospital**	**In-hospital**	**Out-hospital**	**In-hospital**	**Out-hospital**
Q1	1	-	3		1	2
Q2	4	-	2		0	
Q3	4	-	3	2	0	
Q4	5	-	1		1	0
Total	**14**	**-**	**9**		**2**	
				2		2
Overall total deaths	**14**		**11**		**4**	

Deep Dive Reviews

The deep dive into these two SI's has shown that there was opportunity for further learning to be drawn from the review.

Next steps

- To review all shared learning and any gaps / omissions to be addressed as service evaluation of the department. And a process to ensure shared learning takes place and is then evaluated as how effective it has been.
- There was no clear evidence if shared learning had all been completed from the original report.
- There should be an internal process to double check that Lessons Learnt from the original SI report has been completed. Current systems (Ulysses) do not record if this has occurred and difficult to ascertain if all shared learning was disseminated as not included as part of the original action plan.

Conclusion/Recommendation

There has been one expected gynaecological oncology death; no deaths in obstetric or LeDer (Learning disability) deaths within quarter 4 reporting period.

It is recommended that the Board:

a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board.
b. Confirm that the Board are confident that there are effective processes in place to assure the board regarding governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust.

Adult Mortality Quarterly Report

17/18 Quarter 4 – (Jan, Feb & Mar)

- Adult Mortality Q4 report prepared by A. Cringle
- Clinical Author: D. Roberts

Executive Summary

This report updates the Board regarding the Trust systems and processes to review and learn from deaths of patients under their care. This is in accordance with recommendations by the National Quality Board and the Care Quality Commission. It outlines the work taking place operationally and being overseen by Effectiveness Senate and GACA.

Key findings:

- There were no in-hospital deaths during Quarter 4 of 2017-18.
- Adequate progress is being made in systems to reduce mortality
- The Trust rates are within the expected low levels for a specialty hospital.
- The Trust is getting better ascertainment of out of hospital deaths by triangulating with other acute Trusts and MBRRACE-UK midwives

1. Introduction

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

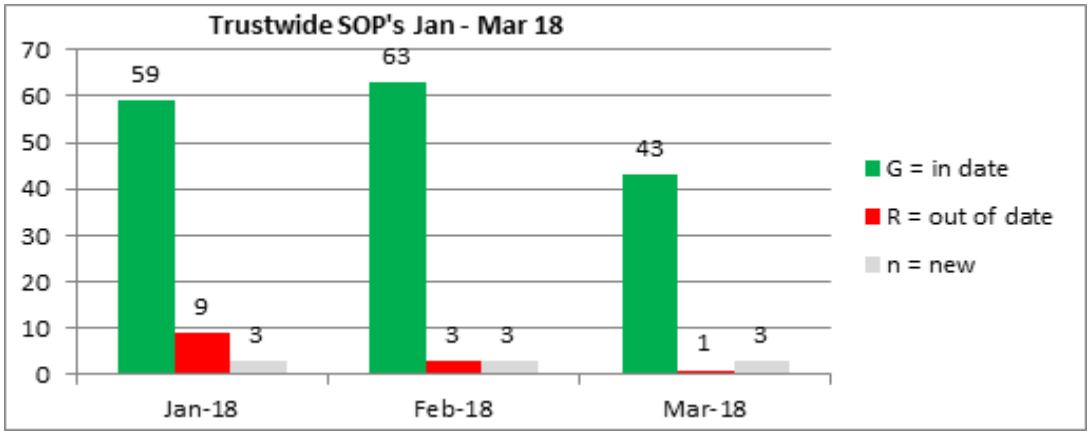
This overview outlines the most recent Trust figures and headline findings in regards to mortality. It provides details to the Board of their own accountabilities while setting out the responsibilities of the Quality Committee and Effectiveness Senate to monitor progress regularly and escalate as required;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

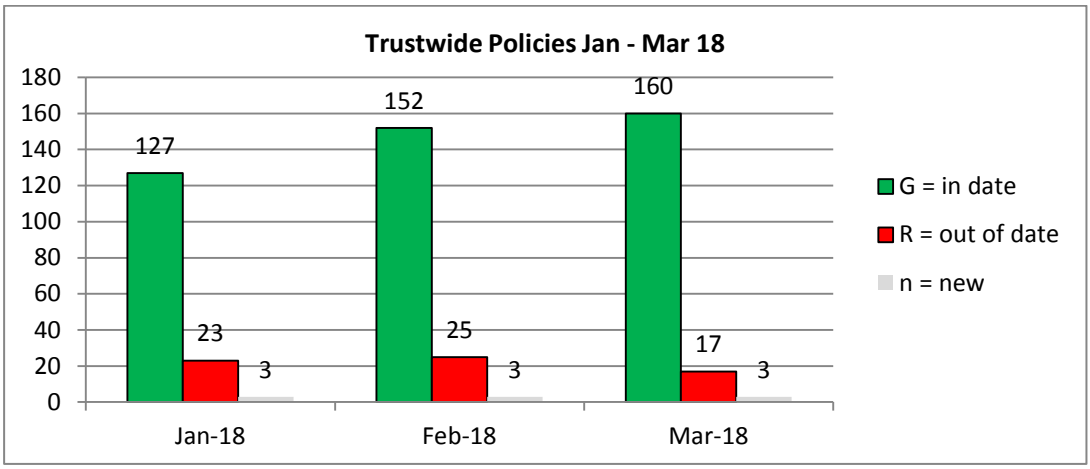
Liverpool Women's NHS Foundation Trust recognises that although most of the adult death it encounters is the expected end point of a known disease process, the principles described above are equally valid to its own services. In the Trust's Risk Management Strategy, commitment is given to minimise risk through the systematic embedding of relevant, efficient and effective risk management processes.

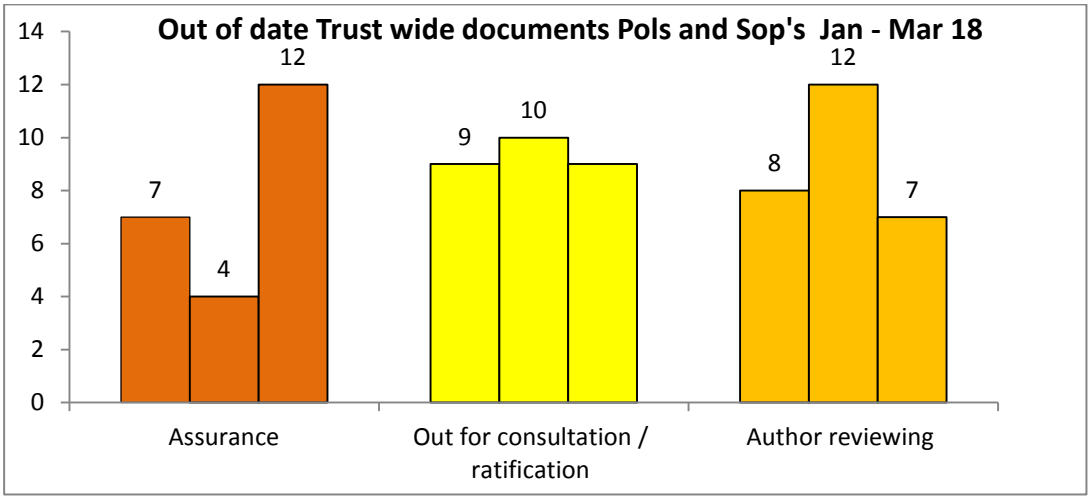
2. Prevention

The below charts are extracted from a 'real time' database, therefore on any given day the numbers could fluctuate slightly either positively or negatively. Outstanding review means that the document is over the due date for document expiry; due for review means 3 months before document expiry date. In date refers to all documents are all current and up to date.

a) Trust wide policies and SOPs (Q4)

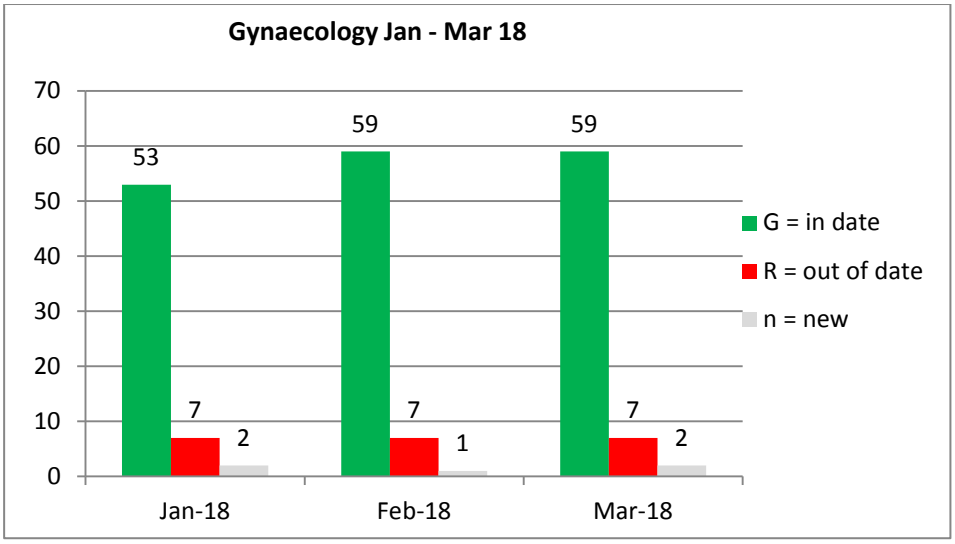

Trustwide SOP's Jan - Mar 18
70
60
50
40
30
20
10
0
59
9
3
63
3
3
43
1
3
Jan-18
Feb-18
Mar-18
G = in date
R = out of date
n = new


Trustwide Policies Jan - Mar 18
180
160
140
120
100
80
60
40
20
0
127
23
3
152
25
3
160
17
3
Jan-18
Feb-18
Mar-18
G = in date
R = out of date
n = new


Out of date Trust wide documents Pols and Sop's Jan - Mar 18
14
12
10
8
6
4
2
0
7
4
12
9
10
8
12
7
Assurance
Out for consultation / ratification
Author reviewing

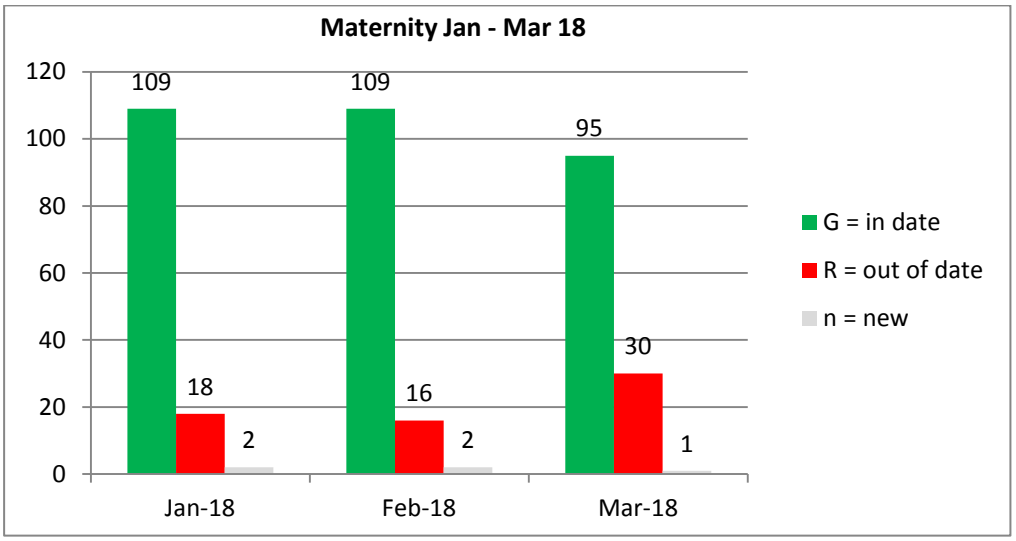
Gynaecology Policies and Guidelines

b) Policies / guidelines are currently being monitored via Gynaecology Clinical meeting.



Maternity Policies and Guidelines

Policies / guidelines are currently being monitored via Maternity Clinical meeting.



The Effectiveness Committee has agreed that by the end of Quarter 4 there should be no outstanding Guidelines or SOPS. The Effectiveness leads have been tasked with improving performance on all guidelines and SOPs within their Divisions.

3. Audit

From April 2017 the Trust has committed to the principle that it must include work of relevance to the highest risk areas for adult mortality in the Clinical Audit Forward plans - including:

- Haemorrhage
- Psychiatric disease
- Sepsis
- Neurological disease
- Venous thromboembolism
- Cardiac Disease

The Annual Audit Programme for 2017 – 18 had been informed by intelligence from a number of different audits in Quarter 4; See below progress table for clinical audits.

Adult Mortality – Clinical Audit progress March 2018

Topic	Clinical Audit Title/s	Progress
Haemorrhage	Use of O Negative blood	Received report including action plan. Results have been presented at Gynae' Divisional Meeting and the Hospital Transfusion Committee. Actions are due for completion Sep-18 (Green 1 on audit database)
	Bedside transfusion (including consent)	Received report including action plan. Results are planned to be presented at the Hospital Transfusion Team meeting and the Hospital Transfusion Committee in May18.

		Actions are due for completion May-18 (Green 1 on audit database)
	SHOT NCA of TACO prevention Require evidence presented	Received report and evidence of action implementation. Awaiting evidence that results have been presented. (Green 1 on audit database)
Psychiatric disease	Antenatal Perinatal mental health management and outcome at Liverpool Women's Hospital	Audit in the process of being registered. As audit not registered 2017-18 it has been carried over to the 2018-19 audit plan. (Red 1 on audit database)
Sepsis	Audit of the management of pregnant women with asymptomatic bacteuria at booking visit *(Previously titled: "Maternal and Congenital sepsis")*	Data collection and analysis is complete. Awaiting final Report including action plan. As audit not complete 2017-18 it has been carried over to the 2018-19 audit plan. (Amber on audit database)
	SEPSIS bundle – Maternity	Data being captured via NUMIS. The HDU delivery group and Sepsis lead will collate themes for presentation in Quarter 4 report. (No audit required)
	Audit of the management of patients with sepsis/compliance to the 1 hour Sepsis Bundle – Gynaecology	Data being captured via NUMIS and is also a CQUIN. AMD has met with Sepsis lead. Sepsis

		guideline will be updated in line with current recommendations. The HDU delivery group and Sepsis lead will collate themes for presentation in Quarter 4 report. (No audit required)
	Postoperative surgical site infections following caesarean sections	Received report including action plan. Overall, we were compliant with guidelines, with all patients receiving prophylactic antibiotics. Therefore, a re-audit is not required. The Maternity Division is exploring vaginal douching prior to CS as an infection risk reduction strategy. Audit completed.
Venous thromboembolism	Assess LWH Gynaecology admissions against NICE QS 03 – VTE in Adults; reducing the risk	Initial audit – completed. Received report including action plan for Re-audit. One action due for completion in relation to PENS, has passed its original completion date of Feb-18 but is being chased up appropriately. (Green 1 on audit dashboard)
Neurological Disease	An audit of outcomes in women who attend the Joint Obstetrics/Neurology clinic	This is no longer required as a clinical audit as it is being monitored through monthly reporting by the performance team.

4. Mortality Dashboard

Due to the small number of in-hospital deaths, it has been agreed with the Head of Governance and Associate Medical Director, that the following table showing the total mortality and the rate of death per 1000 discharges will be used as the mortality dashboard.

501 - OBS	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	1665	1873	1751	1790	1792	1712	1726	1791	1668	1753	1577	1759	20857
Rate per 1000 Discharges	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

502 - GYNAE	Apr-15	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	1004	925	934	1054	1018	1035	1050	1014	1026	823	1000	969	1004	11852
Rate per 1000 Discharges	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

503 - GYNAE ONC	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	TOTAL
Total Mortality	1	0	0	0	0	0	0	0	0	0	0	1	2
Discharges	93	90	81	92	71	69	101	86	74	67	70	65	959
Rate per 1000 Discharges	10.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	15.4	2.1

The two deaths in April 2017 and March 2018 for Gynaecology Oncology represents an overall rate of 2.1 per 1000 Oncology discharges for Q1-4 of 2017/18.

Adult Gynaecological Deaths

Figure 1 below: Cumulative Adult Gynaecology Deaths: Apr 2017-Mar 2018
There have been no deaths recorded in hospital for Obstetrics or Gynaecology; there have been 2 expected deaths for Gynaecology Oncology in this financial year.

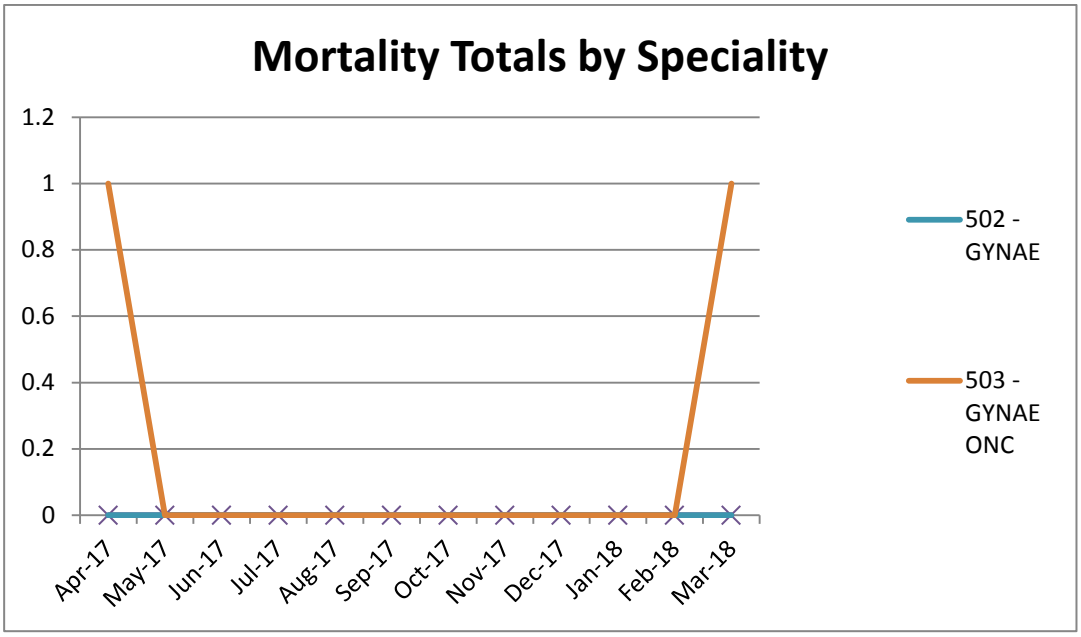
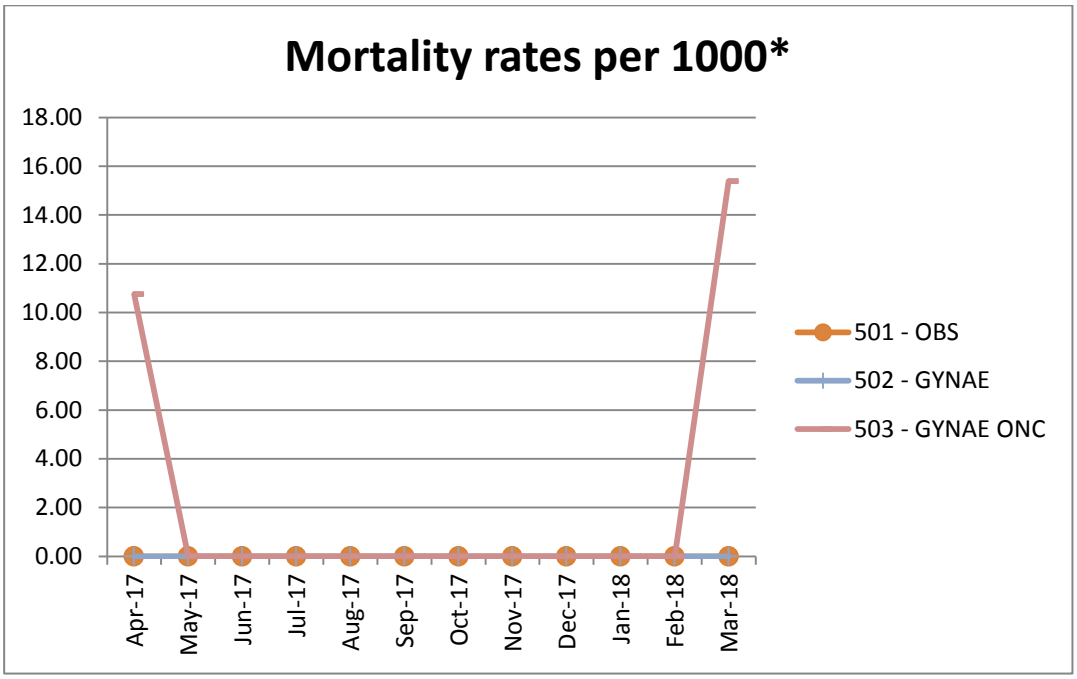


Figure 2 below: Is the rate adult mortality rate per 1000* of the population, overall for the year for Gynaecology Oncology it is 26 per 1000* of the population



Out of hospital deaths 2017-18 Quarters 1- 4

There were two maternal deaths reported externally via MBRRACE-UK national reporting system. Both were due to indirect causes: brain haemorrhage and leukaemia.

Work is now ongoing with other Trusts in developing an alert process of expected or unexpected deaths of patients who had previously been under the care of LWH. Aintree Hospital has already agreed an alert system.

The AMD and Governance team have put in a place a process for triangulating out of hospital deaths with the MBRRACE-UK midwives and the surrounding Trusts to get better ascertainment.

Table below depicts the number of adult deaths in-hospital, including expected and unexpected deaths.

Reporting Quarter	2015-2016		2016-2017		2017-2018	
	In-hospital	Out-hospital	In-hospital	Out-hospital	In-hospital	Out-hospital
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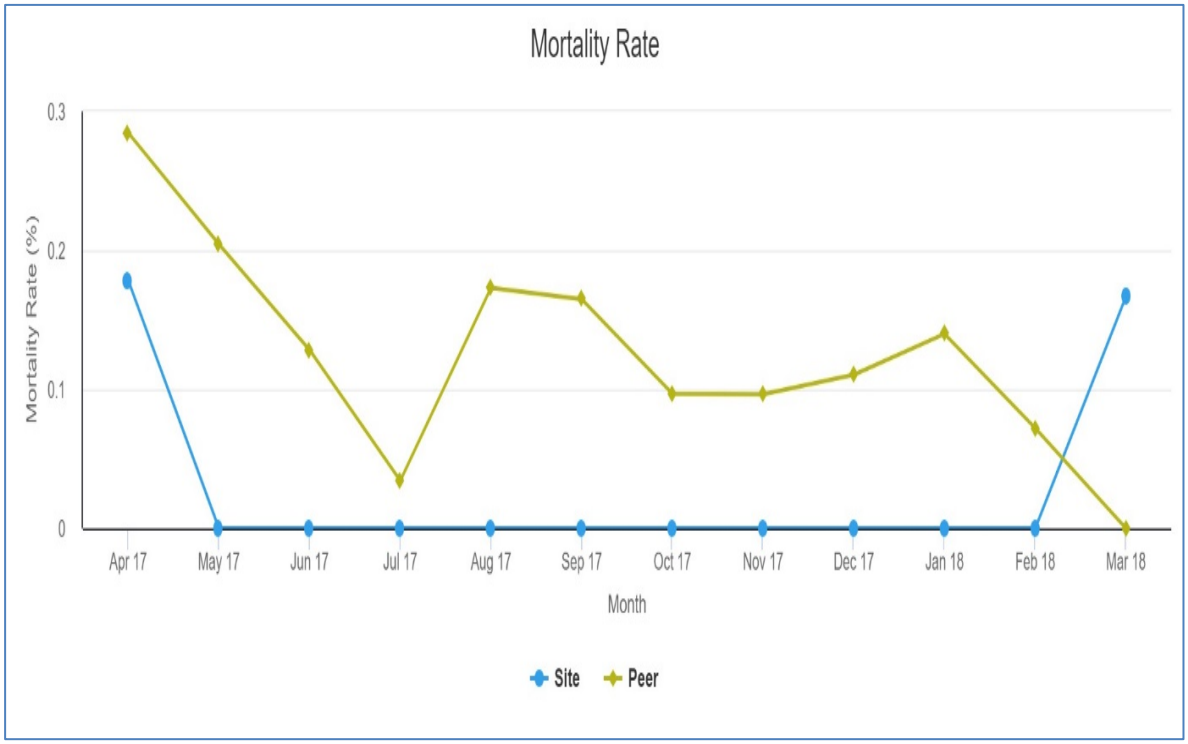
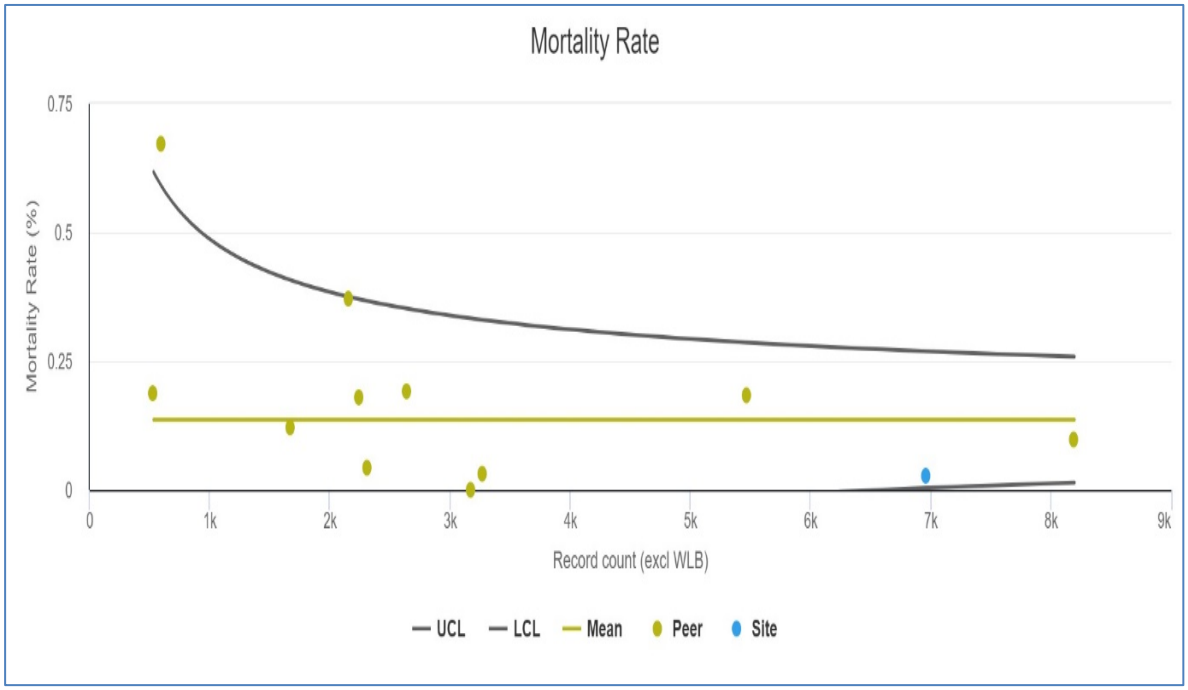
Q2	4	-	2		0	
Q3	4	-	3	2	0	
Q4	5	-	1		1	0
Total	**14**	**-**	**9**		**2**	
				2		2
Overall total deaths	**14**		**11**		**4**	

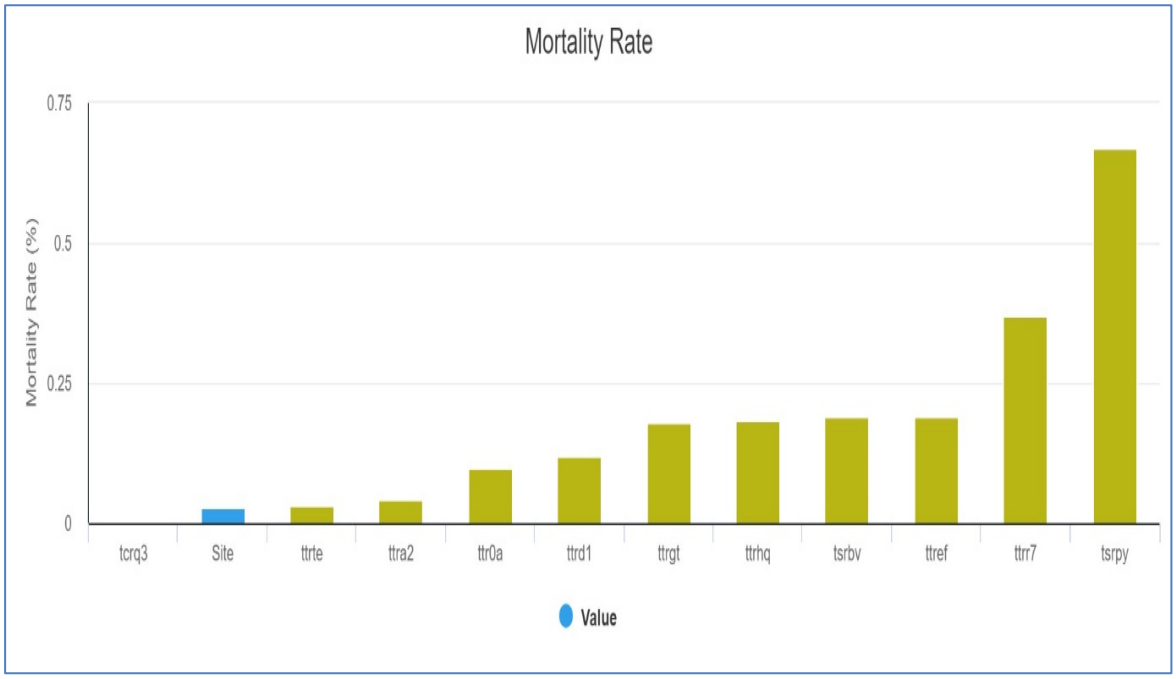
5. Benchmarking

CHKS excludes Bedford and Hewitt patients for better comparison with other Trusts. The chart shows that for the time period April 2017 – Mar 2018 LWH mortality rate is below average compared to other peer Trusts.

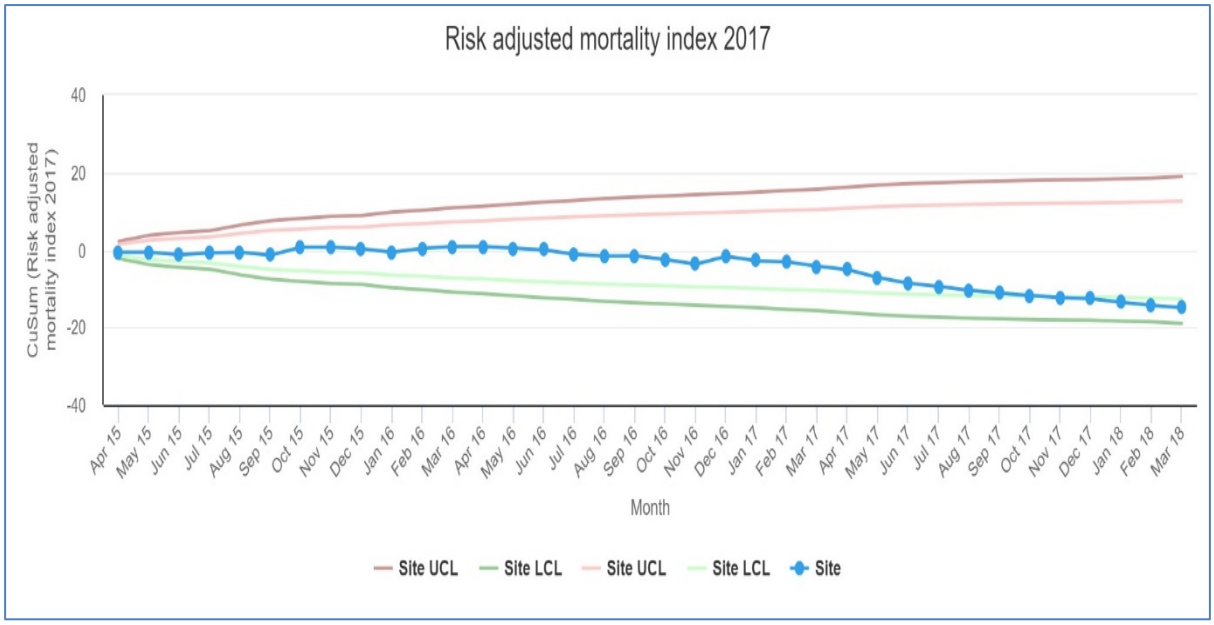
There were 2 deaths at the trust in the period.







The following chart is a CuSum chart for our risk-adjusted mortality index (RAMI) over a three year period with the same filters applied as above. It plots the cumulative difference between the actual number of deaths and number of deaths 'expected' by the model.



What this is showing is that up to December 2016 the number of gynaecology patient deaths at the trust was fairly consistently as would be expected. Since January 2017 the downward trend shows that fewer patients are dying than would be expected. Obviously the numbers of deaths are small but using the long time period and this cumulative chart provides a good view of our Trust trend and should provide assurance to the Board.

Date range: April 2017 – March 2018

Filters: Treatment Function = 502 – Gynaecology, 503 - Gynaecological Oncology; excluding Hewitt Centre and Bedford Clinic (using HRGs)

Peer group (NOTE that there is no peer data for the month of March 2018):

RQ3 - Birmingham Women's and Children's NHS Foundation Trust

RBV - The Christie NHS Foundation Trust

RPY - The Royal Marsden NHS Foundation Trust

R0A - Manchester University NHS Foundation Trust

RA2 - Royal Surrey County Hospital NHS Foundation Trust

RD1 - Royal United Hospital Bath NHS Trust

REF - Royal Cornwall Hospitals NHS Trust

RGT - Cambridge University Hospitals NHS Foundation Trust

RHQ - Sheffield Teaching Hospitals NHS Foundation Trust

RR7 - Gateshead Health NHS Foundation Trust

RTE - Gloucestershire Hospitals NHS Foundation Trust

For the charts above, peers are based on Gynaecology units of a similar size and type to Liverpool Women's Trust. The adult mortality figures for LWH are historically low as the majority of deaths that occur are 'expected' deaths within gynaecology and oncology units.

6. Mortality reviews and Key Themes

Each in-hospital death has a mortality review. All adult gynaecology deaths are discussed at the gynaecology Morbidity & Mortality meeting. As part of this process an adult mortality sheet is completed indicating any potential for improvement in care. Unexpected adult gynaecology deaths trigger a serious incident investigation.

All direct maternal deaths trigger serious incident investigation.

A new mortality review tool has been developed for risk and incident reporting system Ulysses. This avoids losing any paper documents (current system) and allows for searching, monitoring and auditing of an electronic system.

Adult Mortality Quarter 4		
	Maternity	**Gyneacology**
No of Adult Deaths	0	0
No of Mortality Reviews completed	0	0
No of deaths requiring RCA's	0	0
No of deaths due to deficiencies in care	0	0
Mortality Themes	N/A	N/A
Progress v Smart Plans	N/A	N/A
Mortality Outcomes	N/A	N/A
Measures for ongoing scrutiny	N/A	N/A

7. Progress / Learning from Deaths

Currently there have been no deaths to comment on in which to provide specific learning from death outcomes. However, we introduced a deep dive review on the two unexpected deaths in 2016/17 in order to provide assurance to the Board.

The deep dive into these two SI's has shown that there was opportunity for further learning to be drawn from the review.

Overarching conclusion from both deep dive reviews

- Ascertain from IMT about ensuring an access to external ICE until EPR comes on line.
- Develop a process to ensure action plans included lessons learnt and shared learning action points are shared appropriately across the Trust and evidenced and recorded as having been completed.
- Utilise Ulysses system to record all elements of SI investigation including actions and shared learning actions. This will also provide an auditing of SI investigations from a thematic perspective.
- In the event of GP service refusing to provide patient information as part of SI investigation, liaise with CCG. Ensure LWH staff are fully appraised of what information is reasonable to request during and SI investigation, escalation and advice and guidance should be sought from Data protection team.
- Develop a process internally to assess when SI action plans are completed they are subject to review and evaluation of effectiveness of both impact to services, patient outcomes and shared learning.
- Check referral forms from GP and or other Trusts do provide all relevant information for the patient, such as – has the patient recently been referred and what diagnostics are outstanding?

Next steps

- To review all shared learning and any gaps / omissions to be addressed as service evaluation of the department. And a process to ensure shared learning takes place and is then evaluated as how effective it has been.
- There was no clear evidence if shared learning had all been completed from the original report.
- There should be an internal process to double check that Lessons Learnt from the original SI report has been completed. Current systems (Ulysses) do not record if this has occurred and difficult to ascertain if all shared learning was disseminated as not included as part of the original action plan.

8. Horizon Scanning

NICE Guidance:

Nice guidance updates and new guides are presented and assigned owners to review at the monthly Effectiveness Senate, this is then monitored, reviewed and audited through the senate.

A review for the past quarter of NICE guidance and updates has yielding no results in any outstanding or updates to guides in relation to Adult Mortality.

Other Professional Organisations:

Library services provide monthly horizon scanning of any new clinical reports, documents, guidance, and research across a wide range of clinical subject matter for review at the monthly Effectiveness Senate, this is then monitored, reviewed and audited through the senate.

Horizon Scanning Summary for guidance, reports and publications

Subject(s): Adult mortality (Maternity/ Gyneacology)

Period: January 2018 – March 2018

Sources: CQC; NCPOD; NHS Digital, NHS Resolution, Public Health England, RCOG,

CQC – no updates found for the period covered

NCEPOD – no updates found for the period covered

NHS Digital – no updates found for the period covered

NHS Resolution – no updates found for the period covered

Public Health England – no updates found for the period covered

RCOG – no updates for the period covered

9. Conclusion

There has been one expected gynaecological oncology death; no deaths in obstetric or LeDer (Learning disability) deaths within quarter 4 reporting period.

10. Recommendations

It is recommended that the Board:

a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board
b. Confirm that the Board are confident that there are effective processes in place to assure the board regarding governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust

Agenda Item	2018/128

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Corporate Objectives 2017/18 annual review** **Corporate Objectives 2018/19**
DATE OF MEETING:	Friday, 04 May 2018
ACTION REQUIRED	**For approval**
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	Executive Team
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☒ ***3.*** *Failure to deliver the annual financial plan* ☒ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☒ ***5.*** *Ineffective understanding and learning following significant events* ☒ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS*** ☒

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☒ **3.** NHS Compliance ☒		**4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***Board is asked to note delivery of the Corporate objectives 2017/18 and the Corporate Objectives 2018/19.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	***Choose an item.*** Or type here if not on list: ***Click here to enter text.***		
	Date of meeting	***Click here to enter a date.***		

STRATEGIC AIMS AND OUR CORPORATE OBJECTIVES 2017/18
Annual Review

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

Our vision:		To be the recognised leader in healthcare for women, babies and their families
Our strategic aims – WE SEE:	W	To develop a well led, capable, motivated and entrepreneurial **W**orkforce;
	E	To be ambitious and **E**fficient and make best use of available resources;
	S	To deliver **S**afe services;
	E	To participate in high quality research in order to deliver the most **E**ffective outcomes;
	E	To deliver the best possible **E**xperience for patients and staff.
Our values – We CARE and we LEARN:		Caring – we show we care about people; Ambition – we want the best for people Respect – we value the differences and talents of people; Engaging – we involve people in how we do things; LEARN – we learn from people past, present and future.

Corporate Objective To develop a **WELL LED**, capable, motivated and entrepreneurial **W**orkforce;	Executive Lead	Relevant Strategy	Annual review outturn	Delivered (D)/ Partial Delivered (PD)/ did not Deliver (DND)
Improving the Health & Wellbeing of the workforce by moving to upper quartile performance for % sickness absence and stress related absence incrementally between 2015-2018 as measured by the Annual Staff Survey	DoW&M	Putting people First Strategy	• Sickness absence, for the year to date (Feb 2018), currently stands at slightly above the 4.5% target at 4.6%, with stress related absence consistently appearing in the top three reasons for absence • 20 Mental Health First Aiders have been trained within the workforce & cohort of Dignity @ Work Advisers also appointed. • Trust has outsourced its Occupational Health provision to Aintree Hospitals and introduced an Employee Assistance Programme from Mersey-care. This offers additional support to employees including stress resilience training, a 24 hour advice line & access to psychological therapies. • The Health & Wellbeing Strategy is being actively progressed. Yoga, Zumba, Mindfulness, and psychological support for midwives after traumatic events have all been introduced this year. Work is underway to update the HWB Strategy as part of the refresh of the People Strategy (to be submitted to Board in July 2018) • The Trust has achieved the 70% CQiNs target for front line staff flu vaccination uptake	PD
Improving the organisation's climate and increasing the overall staff engagement score (as measured by Annual Staff Survey & the Staff Friends & Family Test) to upper quartile for acute specialist Trusts incrementally between 2015-2018	DoW&M	Putting people First Strategy	• The Trust has implemented quarterly Board listening events. Three events have been held to date with positive feedback from staff. • Board and senior manager visibility has increased including monthly Medical Director & Staff Side Chair walkabouts • Staff Engagement Score 3.8 (3.77 last year). • 2nd Freedom to Speak up Guardian appointed • 12 Dignity at Work Advisors have been recruited and trained with the aim of providing a safe place where staff could discuss issues of inappropriate behaviour or bullying with the aim of resolving these issues at the earliest possible stage. • Staff recommendation of place to work/come for treatment 3.83 (compared to 3.79 in 2016)	PD
Expanding the Trust's reach into its communities through extending its work experience, work training, guaranteed interview and apprenticeship schemes	DoW&M	Putting people First Strategy	• **Disability Confident accreditation** - The Trust was re-accredited as a 'Disability Confident Employer' in July 2017 which required providing evidence that we actively look to recruit disabled people, remove any barriers to them accessing roles and making reasonable adjustments where required. • **Pre-Employment Programme** - The Trust has entered into partnership with Merseycare, Heart and Chest and Walton NHS Trusts with the aim of improving access into NHS Employment. Merseyside Youth Association will recruit the	D

			placements on the Trusts behalf who will offer returnee-ships, internships and pre-employment programmes where those who successfully complete programmes will be offered a bank post. This will aid the Trust in increasing the number of under-represented groups in the workforce including youth and disabled people • **Work Experience and Schools Engagement** - The Trust is working with the Youth Employment Hub to provide support for careers fairs and continue on our annual programme of open days based at LWH following our successful launch of the event earlier this year. Agreement has been reached with local colleges to open up additional work experience placements outside of our busy times to increase our capacity and have seen an increase in students of over 10% in the last year. We expect the increase to continue. Work experience placements are highly evaluated. • **Apprenticeships** - Apprenticeship Levy and Public Sector Duty arrangements in place. The Trust has seen a rise in the number of suitable apprenticeship standards becoming available providing an opportunity to develop in house the talent of those we have recruited locally who would not otherwise have had access to the higher levels of qualification available through apprenticeships	

Corporate Objective To be ambitious and Efficient and make best use of available resources	Executive Lead	Relevant Strategy	Annual Review Outturn	Delivered (D)/ Partial Delivered (PD)/ did not Deliver (DND)
Deliver the financial plan for 2017/18	DoF	Operational Plan 17/18	• The Trust has delivered the agreed financial plan for 2017/18 and has improved on the control total set by NHSI.	D
Deliver the operational plan for 2017/18	DoO	Operational Plan 17/18	• The Trust has delivered the majority of the Operational plan for 17/18 except for the contracted activity levels for Gynaecology and Maternity. The Trust has seen a reduction in referrals to gynaecology and bookings in Maternity that has resulted in reduce activity. This will not significantly impact contracted income in 2017/18 and 2018/19 due to the Acting as One contracting agreement the key CCGs. However, will present a significant income risk in 2019/20.	PD

Corporate Objective To deliver Safe services	Executive Lead	Relevant Strategy	Annual Review Outturn	Delivered (D)/ Partial Delivered (PA)/ did not Deliver (DND)
Maintain regulatory confidence & compliance	CEO		• The Trust continually keeps NHSI and CQC up to date with developments within the Trust and confidence in management. • Regular monthly meetings with NHSI on matters pertaining to the Trust's financial position and future Generations is ongoing. Recognition that the Trust is doing all	D

			things necessary to delivery sustainable services. • Submission of CQC PIR within required timescales. • RTT and Cancer 62day compliance not delivered in year. Actions being taken to rectify the position. Full transparency with both NHSI and CQC. NHSI supportive of Trust's actions.	
Delivery of in year Quality Strategy objectives	MD/ DoN&M	Quality Strategy	• Quarterly reports against the Quality Strategy objectives are presented to the Quality Committee and they evidence good progress across the organisation. The format of that report is currently being revised by the Medical Director and the Head of Governance to add clarity.	D
Maintain Safe Staffing levels	DoN&M	Quality & Putting People First Strategies	• Board receives Bi annual workforce assurance and review. • Monthly staffing metrics reported to the Board of Directors • Daily morning staffing huddle, twice daily if risks identified • Staffing red flags collected as per guidance • Recruitment ongoing for midwifery staff to maintain ratios • Operational escalation policies in place to manage workforce issues proactively • Daily fill rates monitored and reported monthly through to NHSE • Succession planning initiates include LWH being the only NHST in the country to offer an 18/12 MSc in Midwifery for registered nurses	D
Deliver zero C-diff rate and deliver improvements in the management and control of hospital acquired infections	DoN&M	Quality Strategy	• There has been 2 cases of C. Diff, but neither were hospital acquired • Infection Prevention and Control Committee and National Reporting shows improved performance year on year. The DIPC annual report to board in June/July will provide full assurance. • Improvements from learning include environmental upgrades in neonates, staff training, patient and parent hand cleaning facilities and education.	D
Working in partnership with providers and commissioners to ensure quality safe services are delivered to the population of the region.	DoO	Operational Plan	• Developed a working group with Alder Hey to produce business case for a Neonatal single service on two sites. Business case completed and will be presented to April's Trust Board. • Part of the Executive Group of the Women's and Children's Vanguard. • Secured Complex Gynae theatre sessions at the Royal. • Continue to work closely with the Royal and Aintree with regard to the implementation of EPR. • Increased the number of shared back office functions with the Royal and Aintree (Safe guarding, EPRR, Estates,). • Future Generations work with the local economy via the oversight board. • The Trust is well represented by our executive and clinical leaders at the Neonatal	D

			Network, ODN, Strategic clinical Networks, Vanguard and STP. • New partnerships have been established with Southport and Ormskirk and Whiston in response to sustainable services. • Entered in to MOU with CMFT, Lancashire Teaching and Christie hospitals for the submission of the Genetics tender which is now scheduled for xx April, 2018. Continue to work closely with LCL to improve quality, costs and the development of cancer testing. • Worked with CMFT to establish North West region Transportation service. • Hewitt centre have made agreements with CARE for sperm and egg donation services to the benefit of patients. The Wigan, Wrightington and Leigh contract has been signed and the two services are working closely on Drugs procurement, funding packages for private patients and market development.	

Corporate Objective To participate in high quality research in order to deliver the most Effective outcomes	Executive Lead	Relevant Strategy	Annual Review Outturn	Delivered (D)/ Partial Delivered (PA)/ did not Deliver (DND)
Develop closer working relationships with other Trusts in the city with respect to research and innovation	MD	R&D	LWH was central to the city-wide LHP R&D review which was completed and ratified earlier this year and the priorities of LHP now include a focus on issues relating to women's health and the health of newborn babies. We are now engaged in a similar process with the University of Liverpool.	D
Revise the Trust's Research and Development Strategy	MD	R&D	The R&D Strategy has been revised and was ratified by the Board in March 2018.	D
Enhance the Research and Innovation capabilities of the Trust	MD/ DoN&M	R&D	This is encompassed in the R&D Strategy, which seeks to place research at the centre of the Trust's activities, alongside clinical care and teaching. A work plan against the pillars of the strategy is now being followed.	D

Corporate Objective To deliver the best possible Experience for patients and staff	Executive Lead	Relevant Strategy	Annual Review Outturn	Delivered (D)/ Partial Delivered (PA)/ did not Deliver (DND)
Providing 'best in class' patient experience within available financial pressures	DoN&M	Patient Experience Strategy	• New Patient Experience strategy launched in the New Year and monitored through the Experience Senate. World Café Event engaging all stakeholders to develop the Strategy. • Current FFT scores high for recommending this as place to receive treatment and care	D

			• PEX walkabouts any concerns raised are dealt with immediately with the 'Nip it in the Bud' campaign. • New Complaints Process launched April 17 has successfully reduced complaints and increased PALs contacts • Care Opinion Launch with Healthwatch 14th March 2017 and subsequently money secured for a 2yr subscription from November 2017.	

Corporate Objective Delivery of the Future Generations Strategy	Executive Lead	Relevant Strategy	Annual Review Outturn	Delivered (D)/ Partial Delivered (PA)/ did not Deliver (DND)
Support Commissioners and Regulators to agree strategic direction for Trust services, commencing with public consultation and Commissioner Decision Making Business Case.	DoF	Future Generations	• Liverpool CCG has published the clinical senate report which supports the case for change and the preferred option to relocate services to the Central University Campus. This provides an external peer review of the PCBC • The Trust has completed a further strategic outline case which demonstrates the availability and affordability of capital. This extends the financial appraisal contained within the PCBC. • The additional evidence has been submitted to NHS England and a decision is awaited.	D
Work jointly with other providers and regulators to consider future collaboration and organisational form	DoF	Future Generations	• The completed Strategic Outline Business Case Sept 17 details the options regarding future organisational form. • The Royal and Aintree merger is progressing with a proposed merger by April 19 • The Royal Liverpool and Broadgreen NHS Trust has confirmed they would be prepared to move to a shared executive model before any final merger takes place, these avenues have been explored during 17/18.	D
Retain Public and Staff Confidence through an effective Communications and Engagement Strategy	DoW&M	Future Generations	• Fully effective communication and engagement strategy in place throughout the FG process and regular updates provided to the Board.	D

STRATEGIC AIMS AND OUR CORPORATE OBJECTIVES 2018/19

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	E	To participate in high quality research in order to deliver the most **E**ffective outcomes;
	E	To deliver the best possible **E**xperience for patients and staff.
Our values – We CARE and we LEARN:		Caring – we show we care about people; Ambition – we want the best for people Respect – we value the differences and talents of people; Engaging – we involve people in how we do things; LEARN – we learn from people past, present and future.

Corporate Objective To develop a WELL LED, capable, motivated and entrepreneurial Workforce;	Executive Lead	Relevant Strategy	Board Committee
Improving the Health & Wellbeing of the workforce by moving to upper quartile performance for % sickness absence and stress related absence incrementally between 2018-2021 as measured by the Annual Staff Survey	DoW&M	People Strategy	Putting People First
Improving the organisation's climate and increasing the overall staff engagement score (as measured by Annual Staff Survey & the Staff Friends & Family Test) to upper quartile for acute specialist Trusts incrementally between 2018-2021	DoW&M	People Strategy	Putting People First
Expanding the Trust's reach into its communities through extending its work experience, work training, guaranteed interview and apprenticeship schemes	DoW&M	People Strategy	Putting People First
Shaping workforce to meet operational needs through effective workforce planning and partnerships	DoW&M	People Strategy	Putting People First

Corporate Objective To be ambitious and Efficient and make best use of available resources	Executive Lead	Relevant Strategy	Board Committee
Deliver the financial plan for 2018/9	DoF	Operational Plan 18/19	Finance, Performance and Business Development
Deliver the operational plan for 2018/9	DoO	Operational Plan 18/19	Finance, Performance and Business Development
Demonstrate the effective use of resources in providing high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review of Operational productivity and current National initiatives (Model Hospital/GIRFT)	DoF	Operational Plan 18/19	Finance, Performance and Business Development

Corporate Objective To deliver Safe services	Executive Lead	Relevant Strategy	Board Committee
Maintain regulatory confidence & compliance	CEO	All	All
Successfully delivering year 1 of the Neonatal new build	DoO	Future Generations	Finance, Performance and Business Development
Delivery of in year Quality Strategy objectives	MD	Quality Strategy	Quality

Maintain Safe Staffing levels	DoN&M	Quality & People Strategies	Putting People First
Working in partnership with providers and commissioners to ensure quality safe services are delivered to the population of the region. This will include working closely with the following :- • Cheshire and Merseyside Partnership (STP) to develop and influence regional strategy • North West Genetics Partnership - for the tender for genetics services • Alder Hey to implement the Neonatal Single Service on two sites	DoO	Operational Plan	All
Electronic Patient Records project delivery and implementation with required timeframe • To ensure that the modules provided in the new EPR are fit for clinical purpose • To ensure the services are fully prepared to continue delivering services as usual when the new EPR system goes live. • Finance - Deliver the technical solution within the agreed budget	MD DoO DoF	EPR Project Plan	Finance, Performance and Business Development

Corporate Objective To participate in high quality research in order to deliver the most Effective outcomes	Executive Lead	Relevant Strategy	Board Committee
Develop closer working relationships with University of Liverpool with respect to research and innovation	MD	R&D	Quality
Successful implementation of the Trust's Research and Development Strategy to enhance the Research and Innovation capabilities of the Trust	MD	R&D	Quality

Corporate Objective To deliver the best possible Experience for patients and staff	Executive Lead	Relevant Strategy	Board Committee
Providing a patient led experience, continuously seeking feedback to further enhance our service provision.	DoN&M	Patient Experience Strategy	Quality

Corporate Objective Delivery of the Future Generations Strategy	Executive Lead	Relevant Strategy	Board Committee
Support Commissioners and Regulators to agree strategic direction for Trust services, commencing with public consultation and Commissioner Decision Making Business Case.	CEO	Future Generations	Board specific
Work jointly with other providers and regulators to consider options for future collaborations and organisational form.	DoF	Future Generations	Board specific

Retain Public and Staff Confidence through an effective Communications and Engagement Strategy	DoW&M	Future Generations	Board specific

Agenda Item	2018/129

MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**	
DATE OF MEETING:	4 May 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 **2.** Operational Plan **3.** NHS Compliance	☐ ☐ ☒	**4.** NHS Constitution **5.** Equality and Diversity ***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**		***Choose an item.*** Or type here if not on list: ***Click here to enter text.***	
	Date of meeting		***Click here to enter a date.***	

Executive Summary

Data presented 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 May's board report including a peer 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 March 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, completed in Maternity and Neonatal, awaiting final sign off for Gynaecology and the reviewed 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 thermo cooling resulting in an Each Baby counts report

The inpatient wards have been able to maintain fill rates during the month of March 2018; the average fill rate for registered staff was greater than 94.26% day time, 91.70% night time, and the average fill rate non registered staff 97.26% day time 81.10% 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 – interviews held on April 6th, second round of interviews for both maternity leave cover and substantive posts to be held on 3rd May 2018 to address shortfall in maternity.

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 5 red flag incidents, reported under the nursing/midwifery red flag staffing criteria, All reported within maternity services, 1 for epidural provision, not a true nursing red flag, 2 for staffing shortfalls within service, 2 for delay in treatment (awaiting perineal repair and theatre transfer), all were managed appropriately and no harm to patients was noted. Neonatal services reported 12 drug errors relating to omissions, maternity reported 3 drug errors again relating to late administration or omission of medication.

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 fifth consecutive 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 May's board report.

3.0 Summary

During the month of March, 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 to address vacancy and maternity leave cover, 1:1 care in established labour remains a green KPI, and midwifery indicators such as BF rates have not seen a decline in performance. Gynaecology will become the main focus for reporting and ensuring that red flags are reported and discussed with the Gynaecology senior management team.

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.

Appendix 1

Safer Staffing Fill Rate - Gynaecology					
		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Mar-18	Gynaecology	95.1%	94.12%	100.00%	87.72%

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 (%)
Mar-18	Induction&Delivery Suites	77.2%	91.4%	81.7%	84.9%
	Maternity Base	81.9%	81.9%	83.9%	65.3%
	MLU & Jeffcoate	71.0%	74.2%	73.7%	83.9%
	Maternity Total	77.2%	84.2%	80.5%	75.0%

Safer Staffing Fill Rate - Neonatal Care					
		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Mar-18	Neonatal Care	110.5%	96.8%	111.3%	80.6%

Nurse Sensitive Indicators					
	Falls no harm (n)	Falls Harm (N)	Drug Admin Errors (N)	New Complaints (N)	Red Flag Incidents Reported (N)
Gynae Unit					
Delivery Suite			1	1	2
Induction					2
Matbase			1	2	
MLU			1		1
Jeffcoate					
Neonatal			12		
Total	**0**	**0**	**15**	**3**	**5**

Agenda Item	2018/130

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Performance Dashboard Month 12 (March)**
DATE OF MEETING:	Friday, 04 May 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:	☐ ☐
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 note the content of the report.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Finance Performance and Business Development Committee Quality Committee Trust Management Group	
	Date of meeting		Monday, 23 April 2018 Monday, 23 April 2018 Friday, 20 April 2018	

Report

1. Introduction

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

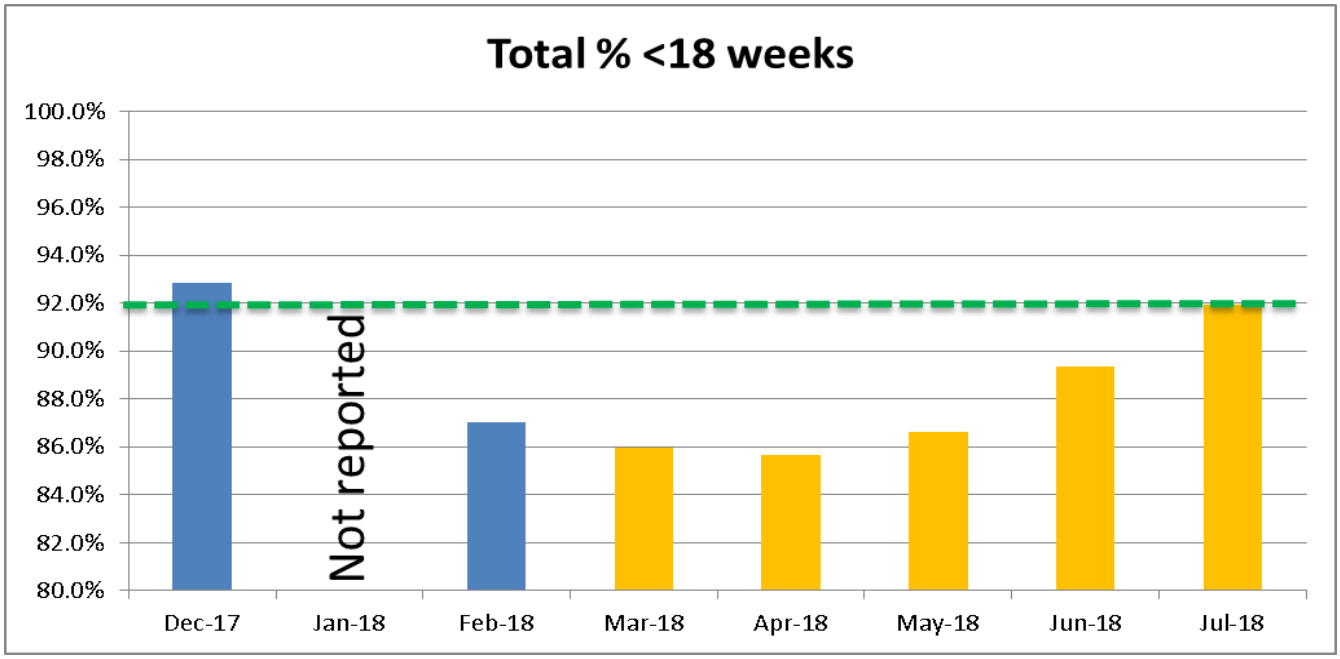
2. NHSI Targets – Access Targets including Cancer targets

2.1 18 weeks RTT and patients waiting greater than 52 weeks targets

The Trust has requested an additional week extension to submitting RTT compliance to ensure that a full validation of information is completed similar to February 2018. The full validation performance was completed on the 25/04/18 and confirmed a 87% achievement against a target of 92% and the recovery plan of 86%

A full report and recovery plan is being monitored and challenged at Finance Performance and Business Development Committee. In this report the Trust is still on target to return to RTT compliance by July 2018. The Trust is expecting RTT performance to reduce slightly in April to 85% before an improving position in May onwards.

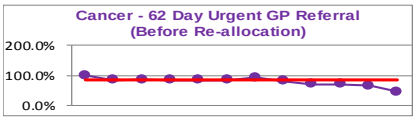
To add some context to this performance the national position for RTT reporting for gynaecology in February is 87.9%.



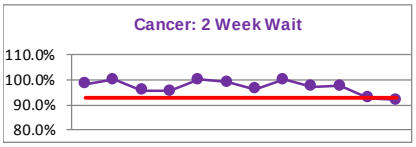
Within the validation the Trust has identified 20 patients (11 were previously reported in February report) with open pathways that have exceeded 52 week wait for treatment. The root cause analysis and harm review is in progress. This has also been reported as part of the RTT submission.

2.2 Cancer Target 62 days – GP referrals (before and after re allocation) and Other Cancer targets reported to FPBD

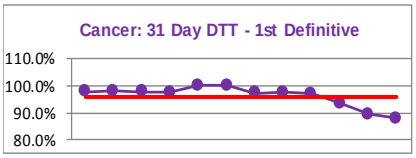
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (Before re-allocation) Provisional Position	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	100.0%	85.0%	87.5%	85.7%	85.7%	84.6%	93.3%	81.8%	71.4%	71.4%	66.7%	46.7%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



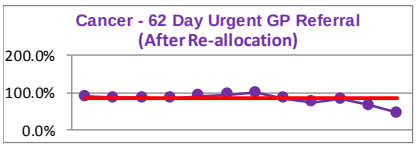
Cancer: 2 Week Wait	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	98.3%	100.0%	95.7%	95.6%	100.0%	99.0%	96.2%	100.0%	97.2%	97.7%	92.7%	92.1%
Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%



Cancer: 31 Day DTT - 1st Definitive	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	97.9%	98.0%	97.9%	97.7%	100.0%	100.0%	97.2%	97.5%	97.0%	93.5%	89.5%	88.0%
Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%



All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation) Provisional Position	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	89.5%	86.4%	87.5%	85.7%	92.3%	95.7%	100.0%	85.7%	75.0%	83.3%	66.7%	46.7%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



All figures for March remain provisional until final sign off via Open Exeter (3rd May 2018) and potential further impact of diagnosed patients and shared allocations with other Trusts. March has seen a similar picture to February with 4 patient breaches of the GP referral 62 day target, three very complex patients not being treated until days 108, 109 and 85 respectively and one other breach at 75 days due to issues of capacity to treat within 62 days.

Performance against all of the above cancer standards has unfortunately failed **provisional March position.** These indicators have been reported to FPBD but should also be brought to the attention of the Board.

The **confirmed February position** was also that all headline targets failed:
62 days – 45% target 85% (4.5 patients out of 10 met standard.) The further two patients referred to Oncology late were reapportioned back to the Trust reducing performance from 66% to 45%.
2 weeks – 92.16% target 93% (188 patients out of 204 met standard) – note referrals **have increased by 36%** since January causing spike in demand.
31 days – 90.1% target 96% (21 patients out of 24 met standard)

The key reasons for failure include the shortages in consultant manpower and the complexity of patients covered by the 62 day standard who require pre-operative intervention that is not covered within LWH's portfolio of services (pathology, echo, MRI, CT).

Work is underway to better align capacity to meet spikes in demand, and to redesign clinical pathways to achieve earlier diagnosis and to establish appropriate timescales for pre-operative work up and access to investigations external to this Trust (echo, MRI etc.)

Escalation processes have been reviewed to provide early warning of capacity issues for first appointment, and to highlight the need for additional operating capacity. The use of an external company to provide additional capacity for colposcopy is being reviewed, together with a review of the Directory of Services, in order to reduce any clinically unnecessary demand. Job plans of the specialist surgeons will be reviewed and, where possible, they will be freed up from general gynaecology commitments to provide more capacity for the cancer workload.

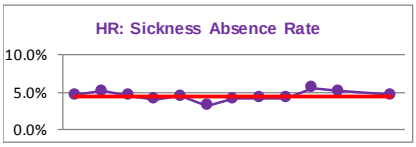
The service will respond as quickly as possible to rectify the performance on waits for first appointment. Similarly, it will be responsive to addressing operating capacity to gain control of the 31 day standard. Delivery against the 62 day pathway will require pathway redesign and agreed ways of working with partners, which will take some time to address. Via the Pathology steering Group, unacceptable waits for histological diagnosis for patients on the cancer pathway will need to be addressed.

The patient from February's report who breached 104 days has had a harm review completed that concluded that delay in treatment due to not being fit for surgery caused no harm. Breach analysis reports have been completed and will be validated in the quality meeting with the CCG.

3. Quality Schedule

3.1 Sickness

HR: Sickness Absence Rate	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Apr-18
Actual	4.6%	5.2%	4.6%	4.1%	4.5%	3.3%	4.2%	4.3%	4.3%	5.6%	5.2%	4.7%
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%



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.

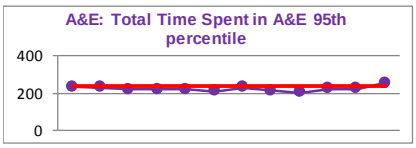
Overall there was a slight increase in short term sickness absence. The proportion of overall sickness split by short term & long term changed from 39%/61% in month nine, to 48%/52%

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.

3.2 A & E Total time Spent in A & E 95th percentile

A&E: Total Time Spent in A&E 95th percentile	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	235	231	220	221	221	210	230	214	204	223	225	254
Target	240	240	240	240	240	240	240	240	240	240	240	240

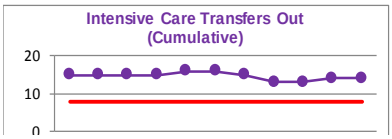


The A & E department has experience 9 days in the month were the number of patients and the acuity has spiked that has caused a number of patients to breach the 4 hour wait in A & E. Overall in the month 54 patients breached out of a total of 1,157. The service did achieve a target of 95% seen within 4 hours. However, this particular CCG target of time spent in A & E failed by 14minutes. The A & E team constantly strive to achieve these targets and have escalation procedures to help them in times of high activity and acuity. The team have plans to use Advance Nurse Practitioners and best utilise the environment to maintain their overall high performance against all A & E targets.

4. Safe Services – Intensive Care Transfer Out

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

Intensive Care Transfers Out (Cumulative)	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	15	15	15	15	16	16	15	13	13	14	14	15
Target	8	8	8	8	8	8	8	8	8	8	8	9



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. Conclusion

The Trust is meeting the recovery plans for the RTT 18 week target, however, the cancer targets are proving more difficult to rectify with a significant increase in referrals in the last two months and a number of complex patients finalising treatment. There is a significant amount of work already underway to improve performance that also relies upon the actions of other providers of diagnostic services.

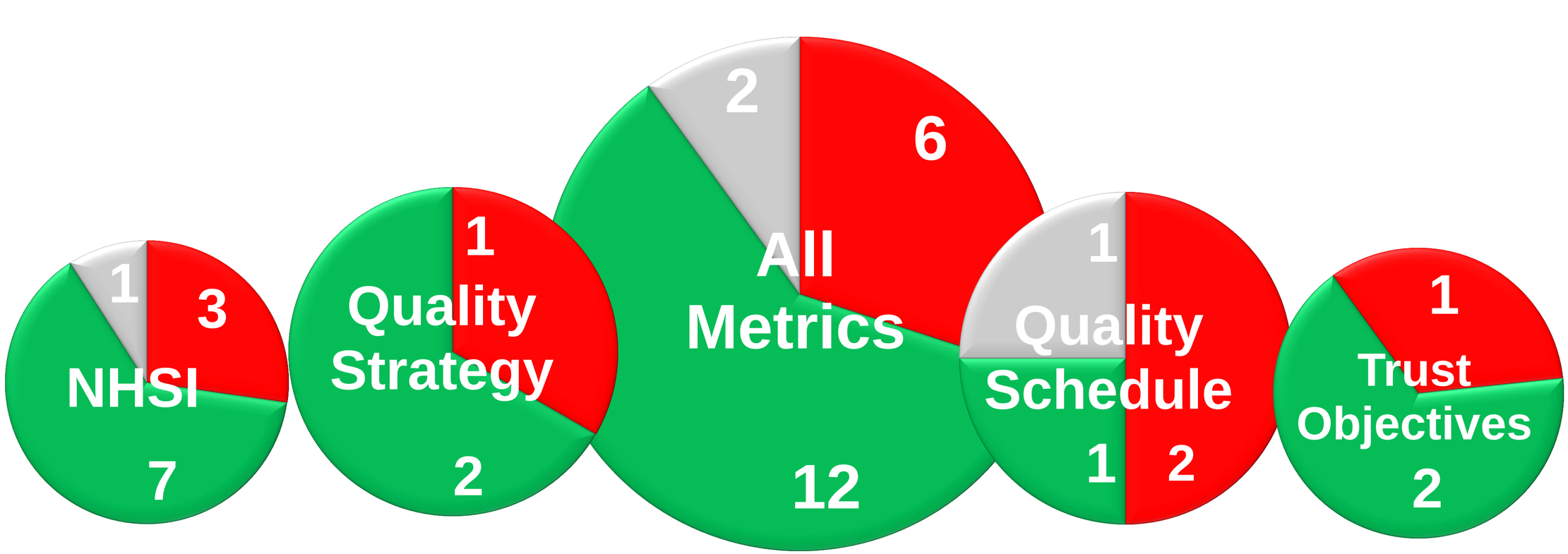
6. Recommendation

The Board note the content of the report.

Performance and Information Department
Performance Team

Liverpool Women's NHS Foundation Trust

Performance Report for Trust Board — Month 12 - March 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 12 - March 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	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	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	0	
NHSE / NHSI Safety Alerts Outstanding	KPI193	Head of Governance	0	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%	4.66%	

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%		
KPI003 Numerator				3416	3573	3396	10385	2967	3035	3096	9098	3169	2783	2689	8641		3236		
KPI003 Denominator				3613	3749	3581	10943	3148	3240	3313	9701	3346	2972	2898	9216		3698		
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%	46.67%	64.5%
KPI1031 Provisional Numerator				11.0	8.5	7.0	26.5	6.0	6.0	11.0	23.0	7.0	9.0	7.5	23.5	9.5	7.0	3.5	20.0
KPI1031 Provisional Denominator				11.0	10.0	8.0	29.0	7.0	7.0	13.0	27.0	7.5	11.0	10.5	29.0	13.0	10.5	7.5	31.0
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%	45.00%		
KPI1031 Final Numerator				7.0	8.5	8.0	23.5	10.0	11.5	10.5	32.0	4.5	9.5	6.5	20.5	9.5	4.5		
KPI1031 Final Denominator				7.0	10.0	10.5	27.5	11.0	12.0	12.5	35.5	4.5	11.0	9.5	25.0	13.0	10.0		
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%	87.72%	85.71%	92.31%	95.65%	92.00%	100.00%	85.71%	75.00%	85.45%	76.92%	66.67%	46.67%	66.13%
KPI1030 Provisional Numerator				8.5	9.5	7.0	25.0	6.0	6.0	11.0	23.0	7.0	9.0	7.5	23.5	10.0	7.0	3.5	20.5
KPI1030 Provisional Denominator				9.5	11.0	8.0	28.5	7.0	6.5	11.5	25.0	7.0	10.5	10.0	27.5	13.0	10.5	7.5	31.0

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%*	40.00%		
KPI1030 Final Numerator				7.0	8.5	8.0	23.5	10.0	11.5	10.5	32.0	4.5	9.5	6.5	20.5	10.0	4.0		
KPI1030 Final Denominator				8.0	10.0	9.0	27.0	10.5	12.0	11.0	33.5	4.5	10.5	9.0	24.0	13.0	10.0		
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	1.0	0.0	1.5
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%	100%	No Pts Applicable	100.0%
KPI1034 Numerator				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	1.0	0.0	1.5
KPI1034 Denominator				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	1.0	0.0	1.5
Complaints: Number Received	**KPI038**	**Ward Manager**	<= 15	10	9	5	24.0	5	11	9	25.0	14	9	6	29.0	2	4	8	14.0

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%	4.66%

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	254
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%	95.8%

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%	4.7%

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	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	8

LWH Trust Objectives 2017/18 Month 12 - March 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%	0.30%
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%	0.30%

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	15

Agenda Item	2018/131

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Month 12 Finance Report**
DATE OF MEETING:	Friday, 04 May 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	Jennifer Huyton, 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: **Click here to enter text.**	☐ ☐
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***Note the Month 12 Financial Position***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Finance, Business and Performance Committee	
	Date of meeting		Monday, 23 April 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 included £1m of agreed investment in the costs of the clinical case for change identified in the 2017/18 operational plan.

The Trust has delivered its 2017/18 control total, improving on the original plan by £0.3m, which was matched by £0.3m of incentive STF. A further £2.0m of bonus STF was then allocated to the Trust, meaning the total value of STF received is £5.5m. Therefore, the final outturn for 2018/19 is a deficit position of £1.3m.

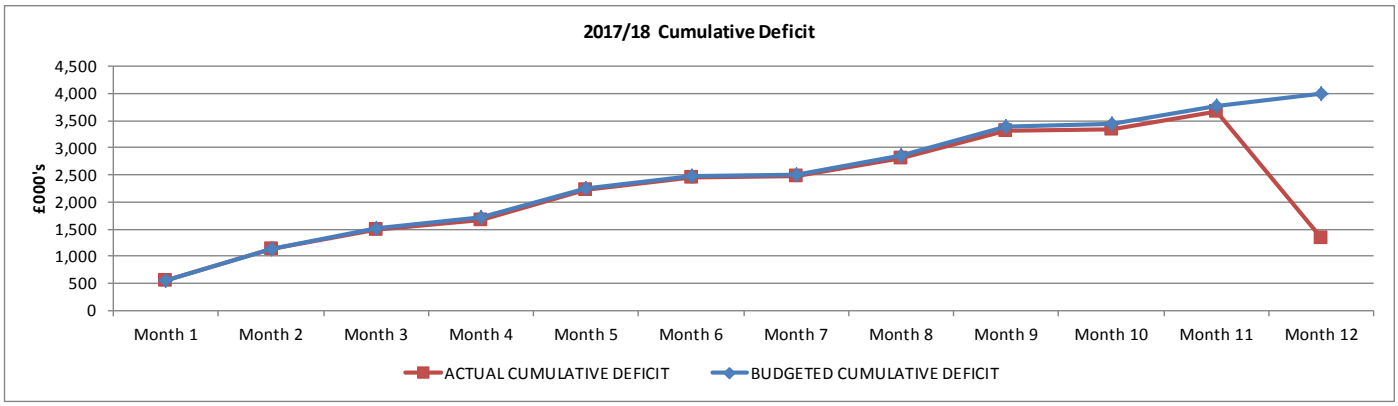
	Month 12 Actual
Planned Deficit (inc £3.2m planned STF)	**£4.0m**
Non-recurrent improvement in year	(£0.3m)
STF Incentive Funding – position improvement	(£0.3m)
STF Bonus Funding – provider sector performance	(£2.0m)
Year-end deficit	**£1.3m**

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

The Month12 financial submission to NHSI is consistent with the contents of this report.

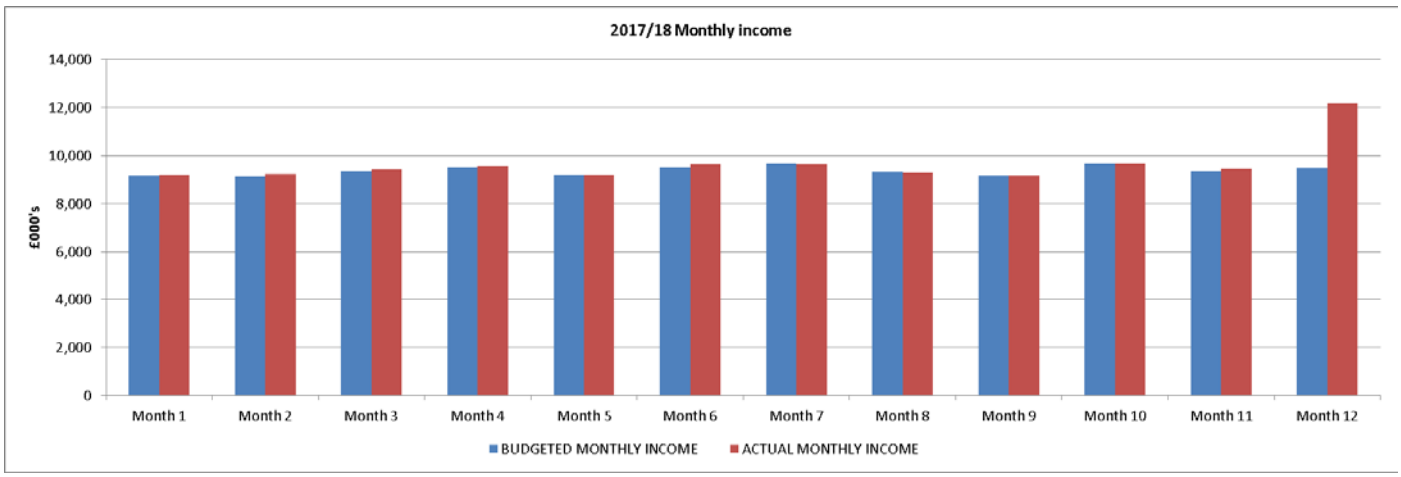
1. Month 12 2017/18 Summary Financial Position

The 2017/18 deficit is profiled below. The variance from plan in M12 reflects the non-recurrent improvement in STF. The detailed position is set out in appendix 1.



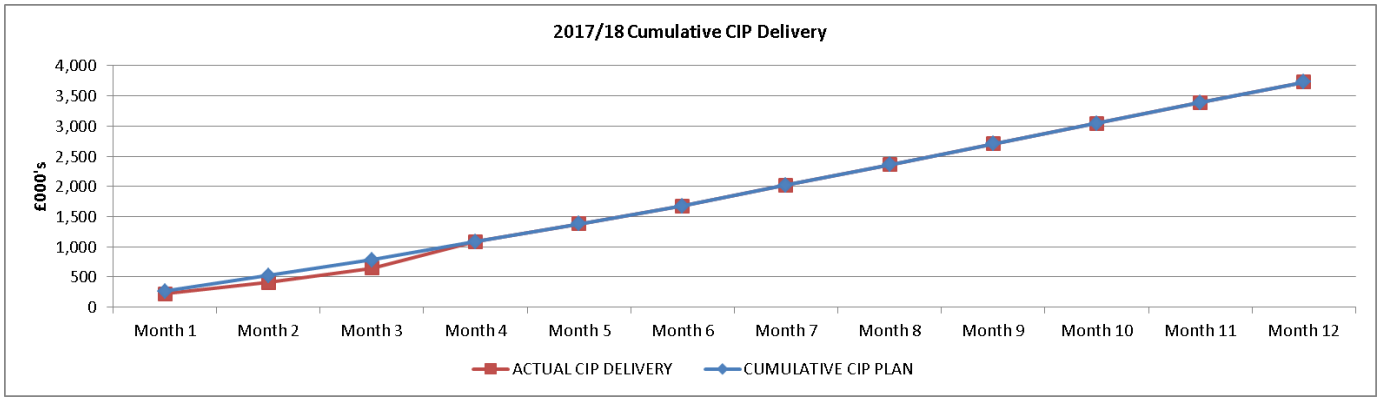
Despite a large proportion of income being under block contract with the Trust's main commissioners, there remained an element of payment by result (PbR) in the 2017/18 income plan. Within the financial plan the block was profiled to reflect expected activity levels in each month. During 2017/18, the CCG block payment was £3.8m higher than would have been received under PbR. This has arisen particularly across both Gynaecology and Maternity, with activity levels in each service below plan.

The income positron by month is set out below. Month 12 income variance reflects the recognition of the associated bonus of STF income.



2. Month 12 CIP Delivery

The Trust has delivered the full £3.7m CIP target for 2017/18, with mitigations reflected in the reported position. £0.7m of this has been delivered on a non-recurrent basis, with £0.2m of this remaining non-recurrent into 2018/19. This is reflected in the 2018/19 CIP target.



Scheme performance and continued CIP delivery into future financial years remains the focus of the Turnaround and Transformation Committee.

3. Service summary overview

Maternity ended the year slightly behind plan (1%). Despite the block contract, lower birth numbers did impact upon PbR income, however the position was in part mitigated through the expenditure budgets.

The gynaecology service also ended the year slightly behind plan (1%) with a reduction in income partly matched by a reduction in costs.

The closing position would have been significantly different had it not been for the block contract, with maternity and gynaecology accounting for 89% of the block contract under-performance. The operational team are reviewing the long term activity plans within these services.

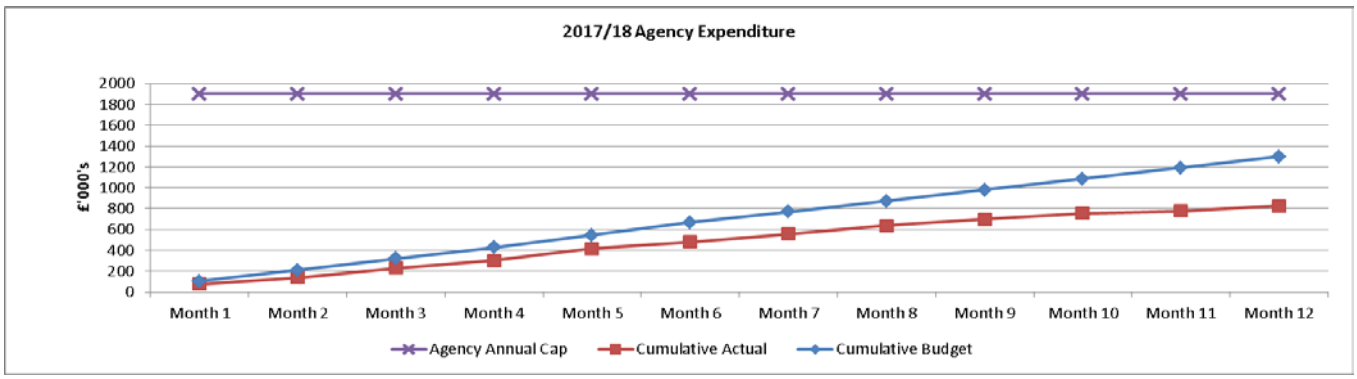
The neonatal service benefitted from transport income over and above planned levels and from activity across the non-block elements of the contract throughout 2017/18, delivering an overall favourable position in year.

The Hewitt Fertility Centre delivered a £2.4m contribution against a target of £2.5m with plans in place to deliver £3m in 2018/19.

Clinical support services delivered within budget to achieve a favourable variance in the year, supported also by a favourable variance across corporate and technical items which includes bonus STF funding.

4. Agency Spend

The annual agency cap set by NHSI for the Trust was £1.9m, against which the Trust incurred £0.8m during 2017/18. The Operational Plan sets out that the Trust will continue to operate within the agency cap in 2018/19, which has been reduced slightly to £1.8m.



5. Cash and borrowings

The cash balance at the end of Month 12 was £6.0m compared to a prior year end position of £4.9m and a plan of £1.9m. Cash is higher than the expected position due to a number of reasons, including:

- Receipt of STF income of £1m during March 2018 which NHS Improvement request is excluded from cash forecasts
- PDC funding for GDE Fast Follower of £1m received in March 2018 plus a further £1m of cash in relation to the Neonatal Build
- Some NHS bodies made payment on the last day of NHS payments that were not expected to be received

The Trust made a drawdown of £2m of Distressed Finance Loans in 2018/19 against a plan of £4m as previously reported. It has been confirmed that repayment of the £5.6m Interim Revenue Loan from 2015/16 has been extended by a year to March 2019.

6. BAF Risk

As the Trust has achieved the 2017/18 control total it is proposed that BAF risk 2168 (delivery of the 2017/18 financial plan) is reduced from 15 to 10 (target score).

As the Trust enters the new financial year this risk should be superseded to reflect the risks to delivery of the 2018/19 control total (score 25).

Risk 1986 (delivery of long term financial stability) score will remain unchanged (score 25).

7. Conclusion & Recommendation

The Board are asked to note the Month 12 financial position, achievement of the control total for the financial year and the proposed changes to the BAF.

Appendix 1 – Board Pack

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M12

YEAR ENDING 31 MARCH 2018

Contents

1 NHSI Score

2 Income & Expenditure

3 Expenditure

4 Service Performance

5 Balance Sheet

6 Cashflow statement

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M12
YEAR ENDING 31 MARCH 2018

USE OF RESOURCES RISK RATING	YEAR Budget	YEAR Actual
CAPITAL SERVICING CAPACITY (CSC)		
(a) EBITDA + Interest Receivable	2,334	4,951
(b) PDC + Interest Payable + Loans Repaid	2,532	4,720
CSC Ratio = (a) / (b)	**0.92**	**1.05**
NHSI CSC SCORE	**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	(2,598)	(6,997)
(b) Expenditure	110,284	110,723
(c) Daily Expenditure	302	303
Liquidity Ratio = (a) / (c)	**(8.6)**	**(23.1)**
NHSI LIQUIDITY SCORE	**3**	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)		
I&E MARGIN		
Deficit (Adjusted for donations and asset disposals)	3,998	1,327
Total Income	(112,608)	(115,651)
I&E Margin	**-3.55%**	**-1.15%**
NHSI I&E MARGIN SCORE	**4**	**4**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)		
I&E MARGIN VARIANCE FROM PLAN		
I&E Margin (Actual)		-1.15%
I&E Margin (Plan)		-3.55%
I&E Variance Margin	**0.00%**	**2.40%**
NHSI I&E MARGIN VARIANCE SCORE	**1**	**1**
Ratio Score 1 = 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%		

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

AGENCY SPEND		
YTD Providers Cap	1,924	1,924
YTD Agency Expenditure	1,301	829
	-32.38%	**-56.91%**
NHSI AGENCY SPEND SCORE	**1**	**1**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%		
Overall Use of Resources Risk Rating	**3**	**3**

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: M12
YEAR ENDING 31 MARCH 2018

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR Budget	YEAR Actual	YEAR Variance
Income						
Clinical Income	(8,569)	(7,402)	(1,167)	(102,883)	(102,633)	(250)
Non-Clinical Income	(918)	(4,787)	3,869	(9,725)	(13,019)	3,294
Total Income	**(9,487)**	**(12,189)**	**2,702**	**(112,608)**	**(115,652)**	**3,043**
Expenditure						
Pay Costs	5,579	4,700	879	67,503	66,576	927
Non-Pay Costs	2,281	3,316	(1,034)	27,053	28,419	(1,367)
CNST	1,311	1,311	(0)	15,728	15,728	0
Total Expenditure	**9,171**	**9,327**	**(155)**	**110,284**	**110,723**	**(440)**
EBITDA	**(316)**	**(2,862)**	**2,547**	**(2,324)**	**(4,928)**	**2,604**
Technical Items						
Depreciation	375	372	3	4,412	4,537	(124)
Interest Payable	36	24	12	432	262	170
Interest Receivable	(1)	(4)	3	(10)	(24)	14
PDC Dividend	124	134	(10)	1,488	1,484	4
Profit / Loss on Disposal	0	0	0	0	(1)	1
Total Technical Items	**534**	**527**	**8**	**6,322**	**6,258**	**64**
(Surplus) / Deficit	**219**	**(2,336)**	**2,555**	**3,998**	**1,330**	**2,668**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M12
YEAR ENDING 31 MARCH 2018

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs						
Board, Execs & Senior Managers	340	322	18	4,085	4,218	(134)
Medical	1,240	1,047	193	14,928	14,835	93
Nursing & Midwifery	990	886	104	28,609	28,462	147
Healthcare Assistants	407	136	271	4,924	4,583	341
Other Clinical	2,013	1,971	41	7,854	7,869	(14)
Admin Support	140	147	(8)	1,679	1,859	(180)
Corporate Services	342	139	203	4,125	3,922	204
Agency & Locum	108	51	57	1,299	829	470
Total Pay Costs	**5,579**	**4,700**	**879**	**67,503**	**66,576**	**927**
Non Pay Costs						
Clinical Suppplies	709	822	(113)	8,521	8,706	(185)
Non-Clinical Supplies	505	771	(266)	6,197	6,347	(150)
CNST	1,311	1,311	(0)	15,728	15,728	(0)
Premises & IT Costs	425	909	(484)	5,118	5,906	(788)
Service Contracts	642	814	(172)	7,217	7,461	(244)
Total Non-Pay Costs	**3,592**	**4,627**	**(1,034)**	**42,781**	**44,147**	**(1,367)**
Total Expenditure	**9,171**	**9,327**	**(155)**	**110,284**	**110,723**	**(440)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M12
YEAR ENDING 31 MARCH 2018

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR Budget	YEAR Actual	YEAR Variance
Maternity						
Income	(3,846)	(3,879)	32	(45,612)	(45,238)	(374)
Expenditure	1,698	1,696	2	20,398	20,314	83
Total Maternity	**(2,148)**	**(2,182)**	**34**	**(25,214)**	**(24,923)**	**(291)**
Gynaecology						
Income	(2,175)	(1,923)	(252)	(25,742)	(25,564)	(178)
Expenditure	859	820	39	10,317	10,249	68
Total Gynaecology	**(1,316)**	**(1,103)**	**(213)**	**(15,425)**	**(15,315)**	**(110)**
Theatres						
Income	(42)	(38)	(3)	(499)	(462)	(37)
Expenditure	640	617	23	7,679	7,626	53
Total Theatres	**598**	**579**	**20**	**7,180**	**7,164**	**16**
Neonatal						
Income	(1,354)	(1,267)	(87)	(16,249)	(16,607)	358
Expenditure	945	919	26	11,341	11,443	(102)
Total Neonatal	**(409)**	**(348)**	**(61)**	**(4,908)**	**(5,164)**	**257**
Hewitt Centre						
Income	(901)	(836)	(65)	(9,971)	(10,056)	85
Expenditure	623	653	(30)	7,471	7,651	(180)
Total Hewitt Centre	**(278)**	**(183)**	**(95)**	**(2,501)**	**(2,405)**	**(95)**
Genetics						
Income	(600)	(592)	(8)	(7,204)	(7,076)	(129)
Expenditure	461	553	(92)	5,535	5,397	138
Total Genetics	**(139)**	**(39)**	**(101)**	**(1,669)**	**(1,679)**	**9**
Clinical Support						
Income	(25)	(26)	0	(295)	(333)	38
Expenditure	759	737	22	9,164	8,963	200
Total Clinical Support & CNST	**734**	**711**	**23**	**8,869**	**8,630**	**238**
Corporate & Trust Technical Items						
Income	(543)	(3,628)	3,085	(7,037)	(10,316)	3,279
Expenditure	3,721	3,858	(137)	44,702	45,338	(636)
Total Corporate	**3,177**	**230**	**2,948**	**37,666**	**35,022**	**2,643**
(Surplus) / Deficit	**219**	**(2,336)**	**2,555**	**3,998**	**1,330**	**2,668**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M12
YEAR ENDING 31 MARCH 2018

BALANCE SHEET £'000	YEAR TO DATE Opening	M12 Actual	Movement
Non Current Assets	**72,688**	**76,313**	3,625
Current Assets			
Cash	4,897	6,013	1,116
Debtors	8,201	8,407	206
Inventories	366	452	86
Total Current Assets	**13,464**	**14,872**	**1,408**
Liabilities			
Creditors due < 1 year	(10,577)	(11,257)	(680)
Creditors due > 1 year	(1,717)	(1,686)	31
Loans	(17,175)	(17,221)	(46)
Provisions	(3,011)	(4,514)	(1,503)
Total Liabilities	**(32,480)**	**(34,678)**	(2,198)
TOTAL ASSETS EMPLOYED	**53,672**	**56,507**	**2,835**
Taxpayers Equity			
PDC	37,420	38,451	1,031
Revaluation Reserve	12,233	15,367	3,134
Retained Earnings	4,019	2,689	(1,330)
TOTAL TAXPAYERS EQUITY	**53,672**	**56,507**	**2,835**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M12
YEAR ENDING 31 MARCH 2018

CASHFLOW STATEMENT £'000	M12 Actual
Cash flows from operating activities	390
Depreciation and amortisation	4,537
Movement in working capital	1,730
Net cash generated from / (used in) operations	**6,657**
Interest received	24
Purchase of property, plant and equipment and intangible assets	(5,044)
Proceeds from sales of property, plant and equipment and intangible assets	134
Net cash generated from/(used in) investing activities	**(4,886)**
PDC Capital Programme Funding - received	1,031
Loans from Department of Health Capital - received	1,000
Loans from Department of Health Revenue - received	2,020
Loans from Department of Health - repaid	(2,974)
Interest paid	(257)
PDC dividend (paid)/refunded	(1,475)
Net cash generated from/(used in) financing activities	**(655)**
Increase/(decrease) in cash and cash equivalents	**1,116**
Cash and cash equivalents at start of period	4,897
Cash and cash equivalents at end of period	**6,013**

Agenda Item	**2018/132**

MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	**Proposed Risk Appetite Statement 2018/19**	
DATE OF MEETING:	**4th May 2018**	
ACTION REQUIRED	**For Approval**	
EXECUTIVE DIRECTOR:	Julie King, Acting Director of Nursing and Midwifery	
AUTHOR(S):	Christopher Lube, Head of Governance	
STRATEGIC OBJECTIVES:	***Which Objective(s)?***	
	To develop a well led, capable, motivated and entrepreneurial *workforce*	**X**
	To be ambitious and *efficient* and make the best use of available resource	**X**
	To deliver *safe* services	**X**
	To participate in high quality research and to deliver the most *effective* Outcomes	**X**
	To deliver the best possible *experience* for patients and staff	**X**
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***	
	Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust	**X**
	The Trust is not financially sustainable beyond the current financial year	**X**
	Failure to deliver the annual financial plan	**X**
	Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision	**X**
	Ineffective understanding and learning following significant events	**X**
	Inability to achieve and maintain regulatory compliance, performance and assurance	**X**
	Inability to deliver the best clinical outcomes for patients	**X**
	Poorly delivered positive experience for those engaging with our services	**X**
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	**X**

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution	**X**	**4.** NHS Constitution	☐
	2. Operational Plan	**X**	**5.** Equality and Diversity	**X**
	3. NHS Compliance	**X**	***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	2 . This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to receive the recommendations of its sub-committees regarding risk appetite and risk tolerance levels for 2018-19 and discuss, agree or amend the Risk Appetite Statement for 2018-19.			
PREVIOUSLY CONSIDERED BY:	**Committee name**	QC, FPBD and PPF		
	Date of meeting	April 2018		

1. Executive Summary

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

What is Risk Appetite?

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

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

What is the Process?

The Liverpool Women's Risk Management Strategy describes the process as follows:

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

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

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

2. Report

Risk Appetite Levels

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

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

Proposal for 2018/19 Risk Appetite Statement

Following review and discussion at sub –committees of the board the following Risk Appetite Statement for 2018-19 is proposed for review by the Trust Board.

To develop a well-led, capable and motivated **workforce** is a **Moderate risk appetite**

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

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

To be ambitious and **efficient** and make the best use of available resources is a **Moderate risk appetite**

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

To deliver **safe** services is a **Low risk appetite**

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

To participate in high quality research and to deliver the most **effective** outcomes is a **Moderate risk appetite**

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

To deliver the best possible **experience** for patients and staff is a **Low risk appetite**

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

3. Conclusion

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

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

4. Recommendations

The Board of Directors is asked to:

a) Approve the recommendations of its sub-committees regarding risk appetite and risk tolerance levels for 2018-19; and
b) Approve the Trust Risk Appetite Statement for 2018-19.

5. Appendix

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

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

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

Agenda Item	2018/133

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Board Assurance Framework for 2017/18 and 2018/19**
DATE OF MEETING:	Friday, 04 May 2018
ACTION REQUIRED	**For Approval**
EXECUTIVE DIRECTOR:	Colin Reid, Trust Secretary
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: **Click here to enter text.**
FREEDOM OF INFORMATION (FOIA):	2. This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to approve the BAF closure for 2017/18 and the resetting for 2018/19.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable Or type here if not on list: ***Click here to enter text.***
	Date of meeting	***Click here to enter a date.***

Executive Summary

Following a review of the Board Assurance Framework (BAF) in 2017 the current structure was agreed and put in place. During the following months up to the end of March 2017 a process of refining and further developing the BAF has occurred. Ongoing work is required moving into 2018/19 to ensure that the BAF remains a live document and this is being taken forward by the Head of Governance and Quality in ensuring that prior to going to any sub-committee and the Trust Board, each risk has been reviewed the by lead Executive Director to ensure gaps in assurance are being identified and actions completed in designated time frame.

The following paper provides an end of year position for BAF risks being managed in 2017/18 and a resetting of the BAF risks 2018/19.

Report

1. Introduction

During 2017/18 a significant amount of work has been completed to not only ensure that key risks are identified on the BAF with a clear indication of the Inherent risk level, current risk level and target risk level. The risk scoring has continued to be aligned to the national risk management framework and the 5x5 matrix (appendix1). Moving forward into 2018/19 the Head of Governance and Quality will be working with the Executive leads and sub-committees of the board to ensure that the appropriate risk domain is used as part of the risk assessment (appendix 2), which will align the BAF risk scoring with the Trust Risk Management Strategy.

2. Issues for Consideration 2017/18

Although specific risk target scores have been identified for each of the BAF risks, in all but 2 cases, the target risk has not been achieved. Therefore further work is required as to the effectiveness and timeliness of the actions identified and their timeframes.

Risk Targets achieved:

Risk number: 1743 – staff engagement and motivation, Putting People first committee considered that the target for this risk had been achieved and that moving into 2018/19 that the target risk should remain score of (L) x (I) 2x5=10

Risk Number: 2168- Failure to deliver the annual financial plan, Finance, Performance and Business Development reduced the current risk score to 15 from 20 in March. The committee have agreed the risk being reset for 2018/19 with the continued target sore of 10.

Risk Targets not achieved:

The remaining risks on the BAF have not met their risk targets of 2017/18 and therefore discussion is required as to the appropriateness of the target scores for that timeframe (annual) or if indeed the risk is more of a long term issue which will require actions over a longer period of time and annual risk target is not valid.

Risk for consideration for removal:

Risk Number: 2167 - Potential for poorly delivered positive experience for those engaging with our services. The Quality Committee discussed the current position of the is risk and in consideration of the work which has been put in place with PAL's+, PAL's experience , the new Patient Experience Strategy that the risk has reduces to a suitable level to deescalate this risk to the corporate risk register.

3. Actions Taken

All agreed changes to the BAF in April 2018 sub-committee meetings have been updated on the 2017/18 BAF and this has been identified as closed on the BAF sheets.

2017/18 BAF (Closed)

Trust BAF April 2018#-04-06 v2.doc

The resetting of the BAF risks has been discussed at the sub-committees and changes required have been actioned and a live BAF document has been established for 2018/19.

2018/19 BAF (Live)

Trust BAF April 2018#-04-25 v1 post

Identified changes for 2018/19 risks:

PPF

1744 – Risk achieved the target position by end 17/18 and proposed a change to the current risk level to (L)2 x (I)5 = 10 and maintain the target risk position as 10. It was felt a reduction in the target risk position over a 12 month period is over ambitious against the PPF strategy which is set over a 3-5 year period

1743 – Risk to remain the same for 18/19, current risk 20 and target risk 10

QC

1986 – Risk and scores to remain the same with 31 March 19 target of 20

1742 – Risk and score to remain with target at 6 (discussion within the QC meeting as to whether with the work we are doing re learning that the score could be less – further discussion required)

1739 – Risk and score to remain with target score of 8 for 31 March 2019.

2184 – The QC debated this risk at length as they felt that the scores were satisfactory, but felt that the target score should be reduced given implementation in October 2018 – target score to be left blank for discussion.

2168 – Risk and scores to remain, but the target risk needs to be changed to 3x4 = 12 to match current risk level.

2167 – The QC discussed whether this risk should remain on the BAF or whether it should be moved to the corporate risk register. The executive team considered whether the risk should be removed however felt that in order to make sure the risk was high on the Board's radar it should remain.

FPBD

1968 - The Trust is not financially sustainable beyond the current financial year – risk and scores to remain and target risk 31 March 2019 to remain at 25

2168 – FPBD agreed the proposed 2018/19 risk –target risk position to remain and date change to "31 March 2019".

General comment from QC and FPBD– moving into 2008/19 we need to make sure the information in the action plan and timescales columns are updated and also to update where can the sources of assurance.

4. Conclusion

The process of yearend review by the sub-committees has been completed and the BAF updated accordingly. Discussions have also taken place as to the risks moving forward into 2018/19 and changes which ae required from the commencement of the 2018/19 cycle.

Then Board can be assured that a robust process for the management of the BAF has occurred during 2017/18, although further work on developing the BAF and associated process is required during 2018/19.

5. Recommendation

The Board is asked to approve the BAF closure for 2017/18 and the resetting for 2018/19.

Appendix 1

Risk scoring = consequence x likelihood (C x L)

	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

The risk matrix above can be used to provide an initial breakdown of the hazards into 4 Categories as follows:

Low Risk	Acceptable risk requiring no immediate action Review annually Place on the appropriate section of the Risk Register
Moderate Risk	Action planned within one month to reduce risk Commenced within 3 months Place on the appropriate section of the Risk Register
High Risk	Actions planned immediately Review Monthly Place on the appropriate section of the Risk Register
Extreme Risk	Immediate Actions required Reviewed weekly by ET Placed on the Corporate Risk Register

Appendix 2
Risk Descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

All risks updated following Sub-Committees of Board in April 2018 and BAF closed for 2017/18- Risk to be transferred to BAF 2018-19

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 • 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 • 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**	2	5	**10**	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. • New programme with Hewitt Centre for recruitment of Drs from India	• Monthly monitoring • Monthly monitoring • 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. **Risks from Risk Register** • 7 x Service Risks	• 5 year financial model produced giving early indication of issues • Business case to Trust Board which identified a solution which minimised deficit, including relocation to an acute site and merger • Early and continuing dialogue with NHS Improvement 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 **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	**Gaps** • Final approval for business case **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	• 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

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	**Outcomes** • Delivery of £4m deficit in 17/18 • Delivery of £3,7m CIP for 2017/18 • NHS I Use of Resources Risk Rating – 3		
			Independent / semi-independent • Monthly reports to NHSI with feedback • Internal audit review of budgetary controls • External audit opinion •			

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

Strategic Objective: To deliver **safe** services

Risk Appetite: LOW

Objective: Long-term clinical sustainability

CQC Domain: Safe

Enabling Strategy: Risk Management Strategy / Pre-Consultation Business Case

Executive Lead: Andrew Loughney

Operational Lead: Devender Roberts

Assurance Committee: 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** • 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	• Update operational plan • Capital plan re: fire provision • Agree a business case for a new build • Commence public consultation	• April 18 • May 18 (revised Date) • Monthly monitoring (external lead) • Monthly monitoring (NHSE lead)
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	• Review current SBAR and 72 hr rapid reporting system – clarity required / possible amalgamation • Develop annual report for Never Events including external information to identify further learning • Further develop safety walkrounds • Additional support and training for risk management / internal review required • Review current risk management training for all staff • Individual assessment of culture across the organisation (risk maturity). • Maintain close involvement with regional and local safety collaborative	• June 18 • July 18 • Sept 18 • Sep 18 (revised date) • Oct 18 • Dec-18 (revised date) • Monthly monitoring (revised date)
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	• Further develop patient safety walk rounds • Regular review of compliance position • Provide assurance to CQC in relation to risks with appropriate information.	• July-18 • Monthly monitoring (revised date) • 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. **Metrics** • Monthly reports to show progress against plan • Highlight report presented against milestones • Monthly review at FPBD **Independent / semi-independent** • MIAA Report (limited assurance) 2017 • Gateway process in place with external verification	**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 **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						

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**

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.	• Explore potential for direct research relationships with other local trusts • Improve data quality provision and oversight • Implement effective domain of the quality strategy	• 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 • Respond to the findings of the CQC's national surveys (Maternity / Inpatient)	• July-18 (revised date) • Sep-18 (revised date) • Ongoing (revised form specific date)
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**

2018/19 Live Board Assurance Framework

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 • 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 • 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 31.3.19		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	**25**	2	5	↓**10 (April 18)**	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. • New programme with Hewitt Centre for recruitment of Drs from India	• Monthly monitoring • Monthly monitoring • 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 31.3.19**		
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: Jennifer Huyton

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 31.3.19		
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: Jennifer Huyton

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 • Workforce cost pressures **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** •2018/19 budget approval (BoD – May' 2018) •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 control total in 18/19 • Delivery of £3.6m CIP for 18/19 • NHS I Use of Resources Risk Rating – 3		

Inherent risk level			Current risk level			Target risk position by 31.3.19		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	**25**	5	5	**25**	2	5	**10**

Strategic Objective: To deliver **safe** services

Risk Appetite: LOW

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

Executive Lead: Andrew Loughney | **Operational Lead:** Devender Roberts | **Assurance Committee:** Quality Committee (QA)

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** • 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	• Update operational plan • Capital plan re: fire provision • Agree a business case for a new build • Commence public consultation	• April 18 • May 18 (revised Date) • Monthly monitoring (external lead) • Monthly monitoring (NHSE lead)
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 31.3.19		
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)

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	• Review current SBAR and 72 hr rapid reporting system – clarity required / possible amalgamation • Develop annual report for Never Events including external information to identify further learning • Further develop safety walkrounds • Additional support and training for risk management / internal review required • Review current risk management training for all staff • Individual assessment of culture across the organisation (risk maturity). • Maintain close involvement with regional and local safety collaborative	• June 18 • July 18 • Sept 18 • Sep 18 (revised date) • Oct 18 • Dec-18 (revised date) • Monthly monitoring (revised date)
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 31.3.19		
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)

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	• Further develop patient safety walk rounds • Regular review of compliance position • Provide assurance to CQC in relation to risks with appropriate information.	• July-18 • Monthly monitoring (revised date) • 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 31.3.19		
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	• 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	• April - 18 • May - 18 • Oct - 18 • Oct - 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		
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 31.3.19		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	**20**	4	5	**20**	2	2	**4**

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)

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 • R&D strategy approved by Board April 2018	• 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.	• Explore potential for direct research relationships with other local trusts • Improve data quality provision and oversight • Implement effective domain of the quality strategy	• 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 31.3.19		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	**20**	3	4	**12**	3	4	**↑ 12 (April 18)**

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)

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. **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	• 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 **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	**Gaps** • Out of date policies • Put of date patient information leaflets **Outcomes** • Staff survey results awaited	• Consider how to enhance assurance levels around the involvement of hard to reach groups. • Ensure all staff , Trust members and volunteers have exit surveys • Respond to the findings of the CQC's national surveys (Maternity / Inpatient)	• July-18 (revised date) • Sep-18 (revised date) • Ongoing (revised form specific date)

Inherent risk level			Current risk level			Target risk position by 31.3.19		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	**20**	3	3	**9**	2	2	**4**