Meeting of the Board of Directors
HELD IN PUBLIC
Friday 5 October 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
249	Apologies for absence Declarations of interest	Receive apologies	Verbal	Chair		-
250	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		Well Led
251	Patient Story	To receive a patients story	Presentation	Patient's parent	1010 (30mins)	Safe, Experience, Well led
252	Minutes of the previous meeting held on 7 September 2018	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1040 (5mins)	Well Led
253	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair		Well Led
254	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1045 (10mins)	Well Led
255	Chief Executive Report	Report key developments and announce items of significance not elsewhere	Written	Chief Executive	1055 (10mins)	Well Led

BOARD COMMITTEE ASSURANCE						
256	Chair's Report from Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1105 (20mins)	Well Led
257	Chair's Report from Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair		Safe Well Led
258	Chair's Report from Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair		Well Led
TO DEVELOP A WELL LED, CAPABLE AND MOTIVATED WORKFORCE; TO DELIVER SAFE SERVICES; TO DELIVER THE BEST POSSIBLE EXPERIENCE FOR OUR PATIENTS AND OUR STAFF						
259	Baby Saver Presentation	For information and assurance	Presentation	Andrew Weeks, Consultant Obstetrician, Maternity	1125 (15mins)	Safe Well Led
260	Mortality Report Q1 2018/19	For information and assurance	Written	Devender Roberts, Associate Medical Director	1140 (10mins)	Safe Well Led
261	Neonatal Build GMP Approval	For approval	Written	Director of Operations	1150 (10mins)	Well Led
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES						
262	Safer Nurse/Midwife Staffing Monthly Report period 5 2018/19	For assurance and to note any escalated risks	Written	Director of Nursing and Midwifery	1200 (10mins)	Safe Well Led
263	Performance Report period 5, 2018/19	For assurance –To note the latest performance measures	Written	Director of Operations	1210 (10mins)	Well Led
264	Finance Report period 5, 2018/19	For assurance - To note the current status of the Trusts financial position	Written	Director of Finance	1220 (10mins)	Well Led
TRUST STRATEGY						
265	Future Generations	For noting.	Verbal	Chief Executive	1230	Well Led

					(5mins)	
BOARD GOVERNANCE						
266	Board Assurance Framework	For assurance and approval	Written	Trust Secretary	1235 (10mins)	
267	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair		Well Led
HOUSEKEEPING						
268	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1245 Meeting ends	Well Led

Date, time and place of next meeting Friday 7 December 2018

Meeting to end at 1245

1245-1255	Questions raised by members of the public observing the meeting on matters raised at the meeting.	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Meeting attendees' guidance, April 2018

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

Before the meeting

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

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

At the meeting

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

Attendance

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

After the meeting

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

Standards & Obligations

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

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

Page 129 Handbook to the NHS Constitution 26th March 2013

Board of Directors

Minutes of the meeting of the Board of Directors
held in public on Friday 7 September 2018 2018 at 1000 hrs
at Liverpool Women's NHS Foundation Trust, Crown Street Liverpool.

PRESENT

Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Mr Tony Okotie	Non-Executive Director/SID
Ms Jo Moore	Non-Executive Director & Vice Chair
Mr Phil Huggon	Non-Executive Director
Mrs Michelle Turner	Director of Workforce & Marketing
Mrs Jenny Hannon	Director of Finance
Dr Andrew Loughney	Medical Director & Deputy Chief Executive
Mrs Caron Lappin	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

IN ATTENDANCE

Mr Colin Reid	Trust Secretary

APOLOGIES:

2018	**Thank You** The Chair advised that a two Team thank you was given in situ at the Hewitt Centre and Genetics. The Chief Executive advised that the Hewitt Centre thank you related to the dedication and hard work of the staff to ensure that the Trust provides an excellent service to its patients of the highest standards of care. She advised that the Board congratulated the team on the recent celebration event for people who have been through successful IVF treatment over the last three decades at the Hewitt Centre and reported on the Centre's celebration afternoon tea event took place on a sunny Sunday afternoon in July at the Hilton Hotel in Liverpool. The Chief Executive advised that among the 500 guests was a room full of babies, toddlers, young children and even some young adults, all of whom were conceived with the help of the Hewitt Fertility Centre's clinical experts. The Medical Director advised on the thank you that was given to the Genetics Laboratory Team who had done a fantastic job in maintaining the high standard IOS UKAS accreditation.
217	**Apologies** – as above. **Declaration of Interests** – None **Welcome:** The Chair opened the meeting and welcomed members of the public and staff to the meeting held in public.

218 **Meeting guidance notes**

The Board received the meeting attendees' guidance notes.

219 **Patient Story**

The Board received a patient story for John Kirwan, Consultant Gynaecologist and Jennifer Ramage, ST5 Obstetrics and Gynaecology relating to a patient that received treatment following a sex change operation undertaken by a service provider in Leicester in 2008 that had gone wrong.

Jennifer Ramage ran through her presentation explaining the background of the patient and the care that was afforded to her over the period from receiving the sex change operation to the work undertaken at the Trust to improve her wellbeing and provide her with a better quality of life. Jennifer Ramage explained the issues faced when the patient was presented to the Trust explaining that the original operation had taken place in 2008; that the patient had both medical history of mental health and was HIV positive; and a social history of poor compliance to medical advice and had previously worked as a sex worker. Jennifer Ramage explained the patients surgical history received at Leicester and at the Trust during the period from 2008 to 2013. In 2017 the patient had presented herself to the Royal Liverpool Hospital and that they were not able to help her condition and she was referred to the Trust's Vulval Clinic at which her medical condition was identified and in April 2018, Jennifer Ramage advised that the Trust undertook an operation on the patient explaining the complexities of the operation. She advised that the operation was a success and provided positive outcomes to the patient that included an excellent cosmetic appearance and a good strength to the vagina which allowed her to be able to have sex again.

The Medical Director commented that this was a very complex patient that if presented at a provider that had women's services she would have received the treatment she needed. He advised that the Royal did not have the necessary women's services to support the patent, which was why she was referred to the Trust. John Kirwan advised that the Trust was seeing more and more of this type of complex patient and there was a real need for services to be able to support the LGBTQ community and the Trust needed to be at the forefront. The Chief Executive supported the comments and advised that there was stigmatism in the system that needed to be eradicated so that all patients are treated appropriately and that as a modern city, Liverpool should be able to commission and provide such services.

The Chair asked for the Chief Executive's thoughts on would make a difference and in response she felt that having multiple services providers on one site where ideas could be discussed amongst clinicians and solutions found was important to the wellbeing of the City's inhabitants. The Chief Executive referred to the physiological aspects of the case and that if all the services, including support services were available on the same site this would provide better outcomes for patients.

The Chair thanked Jennifer Ramage and John Kirwan for the patient story, which was noted.

220 **Minutes of previous meeting held on Friday 1 June 2018**

The minutes of the board meetings held on 1 June 2018 were approved subject to typographical amendments.

221 **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.

222 **Chair's Announcements**

The Chair reported on the following matters:

Council of Governors Meeting 25 July 2018: The Chair reported on the work of the Council at its

meeting on 25 July 2018 and in particular reported on the patient story the Council had received, explaining that it was the same story that the Board had received at the July Board.

Council of Governor Elections: The Trust Secretary reported on the election for Governors in the public and staff constituencies. He reported that the nomination period had now ended and that all but one Staff Group 'Scientists, Technicians and Allied Professional' had at least one nomination.

NHS Providers: The Chair advised on his attendance at an NHS Provider briefing session at which a briefing was given on the merging of posts and shared functions at NHS Improvement and NHS England

Consultant Interviews: The Chair reported on the Neonatal Consultant interviews that had recently taken place and advised that from the interviews two consultants had been successful and would be offered a position.

The Board noted the Chair's verbal update.

223 Chief Executive's report

The Chief Executive referred to her report and commented on the following:

Letter of thanks from University Hospitals of North Midlands NHS Trust: The Director of Nursing and Midwifery referred to the letter of thanks from the Chief Nurse at University Hospitals of North Midlands NHS Trust for the care and compassion the LWH team had shown following the death of Samantha Eastwood.

NHS Capital Funding Regime: The Director of Finance referred to the briefing regarding capital regime and the routes for accessing the limited capital funding currently available. She advised that this set out how capital investment decisions impact on the Department for Health and Social Care (DHSC) and the Treasury (HMT), as well as setting out the capital regimes. The Director of Finance advised that the briefing also reviewed what the future funding may look like noting that successful 'STP' capital bids would be announced in the autumn, but also that there will be further opportunities to access 'STP' capital in the future. She advised that large schemes of over £100m would be assessed separately and would be subject to longer decision making timescales. The Director of Finance advised that the briefing also provided scoring criteria against which the capital bids would be assessed and the she was disappointed to note that the scoring did not give credence to safety.

The Director of Finance advised that she has flagged the issue of safety with NHS Providers who would feedback the concern into the centre. The Director of Finance reported that she had been asked to become a member of NHS providers Capital Working Group which looks to influence and provides feedback into the centre on behalf of all trusts; she advised that safety was such a big issue for the Trust as set out in the Future Generations Strategy and Strategic Outline Case. David Astley supported the comments and could not understand why safety was not a criterion of any capital investment decision. He felt this was an essential part of any need to improve patient care.

Hospital: The Chief Executive reported on the award-winning BBC documentary series 'Hospital' which was coming to Liverpool and was filming at several hospitals across the city, including the Trust. She advised that the series unveils the incredible work of the NHS and the day-to-day decision-making of those who work within the Trust, the challenges and pressures they face and the patients they care for at a time when the NHS continues to be under scrutiny. Filming would commence on the 8th October for around seven weeks and was a fantastic opportunity to showcase the Trust's services and the pressures it faces day to day.

The Board noted the Report from the Chief Executive.

The Chair introduced the Chairs reports from the Board Committees noting that they relate to July meeting and asked that the Board take the reports as read and that the Chairs report on only those key issues that needed further discussion.

224 Chair's Report from Finance, Performance and Business Development Committee

Jo Moore, Chair of the Finance, Performance and Business Development Committee (FPBD) presented her report for the meeting held on 23 July 2018 and highlighted the key matters discussed at the meeting. In particular Jo Moore advised on the financial performance of the Trust for month 3 and the assurance the Committee had received on year end delivery of the control total.

Jo Moore reported on the operational performance and in particular performance against RTT and 62-day caner both of which would be reported on under the Operational Report agenda item. Referring to the Emergency Planning Resilience and Response Bi-Annual Review, Jo Moore reported that the Committee had noted significant progress made against EPRR requirements supported by the provision of the Emergency Planning and Business Continuity Manager from Aintree.

Jo Moore advised that the Committee the BAF risk scores remained unchanged and reported that Board approval for the funding to bring forward the enabling work for the neonatal redevelopment project had been approved by the Board out of meeting.

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

225 Chair's Report from Audit Committee

Ian Knight, Chair of the Audit Committee (AC) presented his report for the meeting held on 23 July 2018 and ran through the assurances received.

Ian Knight reported on the meeting he and the member of the Committee had with the External and Internal Auditor without the management team and advised that no concerns had been raised during the discussion. He went on to explain that all comments on the relationship with the Trust had been positive with emphasis on a great working relationship and cooperation.

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

226 Chair's Report from Quality Committee

Susan Milner, Chair of the Quality Committee held on 24 July 2018, ran through the report speaking to the key items. In particular Susan Milner reported on the key assurances the Committee receive from the Safety, Experience and Effectiveness Senates as part of the Governance framework. She highlighted the issues faced by the Trust in delivery of RTT and 62-day cancer and advised that assurances were provided that no harm had been caused to patients.

Referring to the BAF, Susan Milner confirmed the changes made to the anticipated year end (31 March 2019) EPR risk score, relating to the "Failure to deliver an integrated EPR against agreed Board plan" to the maximum 25. Susan Milner reported on the mitigations being put in place to address non delivery including the extension of the Meditech contract and reviewing other options should the delay in delivery of the EPR system be delayed longer term.

The Chair thanked Susan Milner for her report which was noted.

227 Chair's Report from Charitable Funds Committee (CFC)

Phil Huggon, Chair of the CFC Committee held on 10 July 2018, highlighted the key items contained in his report.

Phil Huggon reported on the appointment of Sylvia Pearl, Head of Fundraising which was one of the recommendations from the commissioned charity fundraising feasibility review. He advised on the financial position of the Fund and noted that income had continued to reduce across all funds; action would be undertaken to review the financial position and identify any issues behind the reduction of income and agree a clear strategy for income generation going forward, under the direction of the Head of Fundraising.

The Chair thanked Phil Huggon for his report and asked the Board to approve the amended terms of reference attached to the Report. The Charitable Funds Committee Terms of Reference was approved and the report noted.

228 Staff Listening Event Feedback – Fair and Just Culture Project

The Director of Workforce and Marketing presented the Staff Listening Event Feedback on the Fair and Just Culture Project and reported that the event was well attended by staff, however there were very few front line staff attending which would be addressed for the next event in November.

The Director of Workforce and Marketing advised that the feedback from the event would be used alongside additional data gathering exercises such as the annual staff survey and cultural surveys and would provide a well-informed project base-line highlighting issues that staff feel impede the organisation from demonstrating fair and just culture. She advised that the establishment of Listening events as a vehicle for engaging staff continued to be well received and of value to staff who welcome the opportunity to exchange open and honest views with the Board.

Referring to the outcome of the Listening Event, the Director of Workforce and Marketing advised that there was a real appetite in the room for cultural change which would encourage all staff to be kinder and have greater understanding and respect for each other. She felt there was plenty of energy for change.

The Director of Workforce and Marketing reported on the national attention the project was receiving and referred to the visit and training provided by David Marx, which he was provided free of charge. She felt that David Marx contribution would provide impetus to the fair and just project as it moved forward.

The Chair thanked the Director of Workforce and Marketing for her report and asked if there was a requirement to have a NED lead for the project. In response the Director of Workforce and Marketing advised that the national Freedom to Speak Up Guardian office saw the role of the local guardian as being responsible for supporting the delivery of the change in culture. With regards to a NED lead, she advised that there was no formal requirement to have a NED lead however if there was the role would fit with the role of the Senior Independent Director, Tony Okotie, given the current links to the Guardian through the Raising Concerns policy.

The Chair thanked the Director of Workforce and Marketing for the feedback from the Listening Event which was noted and commented on the Boards continued support of the project.

229 Equality and Diversity

Rachel London, HR Business Partner joined the meeting to present the Equality and Diversity update and ran through her presentation explaining the progress that had been made in the Trust and what the key issues were. She explained the duties of the Board, in particular that the Board was able to demonstrate and evidence its commitment to promoting equality and diversity with and beyond the organisation. Rachel London advised that the sources of evidence would include: evidence of work done outside of the organisation with either members of the nine protected groups or other disadvantaged groups; speeches/talks outside of the Trust with an E&D element; reports presented Board/senior leaders/other audiences; minutes from meetings where the Board has promoted

equality; participation in Board leadership programmes for equality/inclusion; active promotion of equality-based initiatives for services within the Trust or workforce initiatives; and attendance at the Diversity and Inclusion Committee.

Referring to a recent report published by the Good Governance Institute with Diversity by Design, Rachel London advised that the report seeks to ask Board to: articulate the link between increased diversity of workforce and delivery of strategic aims including patient outcomes and staff satisfaction; ensure the organisation gains insight into the 'diversity deficit' through focused work with staff to understand their attitudes to promotion, career development and opportunities; ensure a review of recruitment practices is undertaken to ensure fairness and change approach to diversity training to integrate into leadership training; and set targets around making organisation more representative of patient group it serves.

The Medical Director advised that he received an identical presentation at the Royal Liverpool Hospital and noted that recruitment into non clinical positions seems to lag behind clinical appointments. He wondered if there was an opportunity to develop in partnership with other trusts in the city a recruitment process that supported the diverse population of the city. The Director of Workforce and Marketing agreed with the comments and advised that there was a requirement to bring services together to provide real synergy across the city. Tony Okotie noted that training in E&D was mandatory but was the training going far enough to mitigate any unconscious bias at recruitment.

The Chief Executive referred to work the Board undertaken some years ago where it engaged with the community providing sponsorship and mentoring in senior schools to support students from less privileged backgrounds to help realise their dreams. She advised that two students who had, following support from the Board, gone to medical school advising that they not have done so had the Board not got involved. The Chair supported the comments and felt that as part of the Boards development, it could look at how it gives something back to the community it serves.

The Board reviewed further its responsibilities noting that there was a need for the Trust to set targets against its E&D objectives and agreed that by the end of March there would be a clear and realistic action plan. The Director of Nursing and Midwifery supported the approach and agreed to work with the Director of Workforce and Marketing to and the HR team to help embed the principles of E&D in the Trust.

The Chair thanked Rachel London for her presentation which was noted. The Chair asked that the Board members complete the E&D questionnaire that had been passed to each of them during the meeting.

230 Guardian of Safe Working Hours Report.

The Medical Director presented the Guardian for Safe Working Hours Report, on behalf of Jeff Shaw who was unable to attend due to having to attend a clinic at Aintree. He advised that Jeff Shaw does a great job in his role as the guardian and referred to the very low number of exception reporting in the Report.

Referring to the exception reporting in Theatres, the Medical Director advised that this was as a consequence of clinical need due to complexity of patient which resulted in overruns. Where this had happened, the doctors in training would normally receive their time back.

The Medical Director reported on the Guardians engagement with the junior doctors' and advised that he continued to attend doctor in training inductions which helps to make new doctors aware of the role of the guardian. Referring to the problems with rota gaps reported, the Medical Director advised that the Medical Staff Committee was looking at how the services can be delivered.

The Medical Director advised that there were no particular themes coming out of the Report that needed escalation. The Director of Operations commented that the Report concentrates on "overruns" in Theatres but not "underruns" and asked whether there was an offset of time in these circumstances. The Medical Director understood that underruns were not measure and that this maybe something to look at in the future.

The Chief Executive commented that the Trust did not have the same issues than acute trusts with A&E for example, where junior doctors would be staying over their normal shifts due to the number of patients and complexity of cases that they would be required to see.

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

231 Safer Nurse/Midwife Staffing Monthly Report Period 3&4 2018/19

The Director of Nursing and Midwifery reported on the safer staffing report for month 4. In particular she reported on the fill rates within in patient wards that had been maintained with average fill rate for registered staff day time of 102.68% with 96.48% for unregistered staff; for night time staff the average fill rates for registered staff was 101.58% and for unregistered 93.46%. The Director of Nursing and Midwifery advised that maternity displayed the greatest increase in fill rates for registered staff due to recent recruitment drives within the services.

Referring to how safe staffing is assessed, the Director of Nursing and Midwifery advised that this was undertaken on a daily basis by the relevant Divisional Matrons, with the duty manager responsible for the evenings and weekends within the divisions; the on call senior manager was responsible for ensuring safe staffing of all ward areas across the Trust.

The Director of Nursing and Midwifery reported on the red flags and advised that investigations into them concluded that staffing levels and skill mix were safe at the time and did not contribute directly to the incidents.

Referencing the national picture, the Director of Nursing and Midwifery advised that there was no nationally agreed measure of the shortfall in the nursing and midwifery workforce in England, however, Health Education England state that there were 36,000 nursing vacancies in the NHS in England equating to a vacancy rate of 11%. She explained that the Trust's vacancy rates in nursing and midwifery was between 4.87% and 8.77% over the reporting period.

The Director of Nursing summarised the position and reported that all wards were considered safe with low/no levels of harm and positive patient experience across all inpatient areas indicating that safe staffing had been maintained. Referring to Gynaecology, the Director of Nursing advised that this service would remain the focus for monitoring of recruitment and reporting of incidents ensuring that red flags were discussed and acted on.

The Chair thanked the Director of Nursing and Midwifery for her report. The Board noted the content of the report and was assured that appropriate information was being provided to meet the national and local requirements; and that the Trust had the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload.

232 Performance Report Period 4 2018/19

The Director of Operations presented the Performance Report for period 4 2018/19 and reported that the Trust was continuing to deliver the national targets to date with the exception of RTT 18 weeks and a number of the cancer targets. The Director of Operations advised that 18 week RTT and Cancer recovery plans had improved and the backlog queues had reduced, however due to further reductions in consultant availability delays would continue to impact on the Trust's ability to reduce

backlog and therefore the risk in the recovery of the targets back to compliance. He advised that both recovery plans assume that consultant appointments of the calibre required by the Trust would be completed in October; if this was not the case then there would be a significant risk to the delivery of the recovery plan.

Referring to delivery of the RTT recovery plan and indirectly the delivery of the Cancer recovery plans, the Director of Operations advised that he was in discussion with an outsourcing private service provider, Medinet who would be able to work on site at weekends to deal with the less serious Gynaecology cases and would support the reduction in backlog cases. This was currently being considered by the Executive Team.

The Director of Operations referred to the letters received from NHS Improvement and NHS England both of whom had requested all elective care providers to focus on delivery of delivery of targets by the end of March 2019. He advised that the Trust had submitted its projections based on assumptions that: there was no change in referral patterns; the Trust would be successful in the recruitment to vacant consultant posts; the Trust was able to outsource patients. The Director of Operations advised that the Trust was not an outlier and its current RTT and Cancer targets were in line with what was happening nationally; however this was not good enough and needed to do what was right for patients by bringing the numbers down and delivering the level of target expected. Referring to any harm to patients, the Director of Operations advised that harm reviews were carried out for all patients and no harm had been identified.

The Medical Director commented on the recruitment of consultants and the difficulties the Trust had been facing in attracting and recruiting the right calibre. He explained that there had been a number of prospective consultants who fitted the job specifications however they had decided to take up a post in another hospital due to the Trust being on an isolated site with the inherent risks that that brings. David Astley, referring to the use an external provider at the weekends, supported the proposal. He felt it was important to make sure, as a Trust that patients were receiving the best possible care.

The Chief Executive recognised the concerns regarding the recruitment of consultants and reported that this had been foreseen as part of the Future Generations work the Trust had undertaken. She felt that if recruitment continued in the current trajectory then there would need to be some consideration on whether the Trust could continue to provide services in the future. She explained that if the Trust was not able to recruit due to being on an isolated site with all the risks that that brings then patients would need to go elsewhere to receive their care.

The Board noted the Performance Report for period 4 2018/19, noting in particular the risk of non-delivery of RTT and Cancer due to both lack of consultant capacity and diagnostics. The Chair thanked the Director of Operations for his report.

233 Financial Report & Dashboard Period 4 2018/19

The Director of Finance presented the Finance Report and financial dashboard for month 4, 2018/19 and reported that at month 4 the Trust was reporting a deficit of £1.2m against a deficit budget of £1.18m, giving a year to date favourable variance of £0.6m. She explained that this was an improvement on prior months which gives rise to reasonable assurance that the control total would be delivered at the end of the financial year. However the underlying position moving into future years remains a concern, explaining that the favourable position was due to the acting as one contract which provided £1.1m additional income earned year to date than what would had been earned under PbR. The Director of Finance advised that the Trust delivered a 'finance and use of resources' rating of 3 in month which was planned, and continued to forecast delivery of the £1.6m end of year deficit control total.

The Director of Finance advised that delivery of CIP remained a key risk. She reported that failure to deliver CIP and any subsequent failure to achieve the control total would result in the loss of £3.6m Provider Sustainability Funding (PSF). The Director of Finance reported that the Trust had a £3.7m CIP target for 2018/19 and advised that at Month 4 the CIP was on track to be delivered. She explained however that there was significant risks to deliver the required CIP and reported on the potential non delivery of CNST Maternity incentive which was planned to be received from month 6.

The Director of Finance reminded the Board on the process the Trust had taken to provide a submission to NHS Resolution relating to reducing stillbirths, neonatal and maternity deaths and brain injuries which would have seen the Trust qualifying for at least a 10% discretionary rebate of CNST maternity contributions for 2018/19. She explained that the Trust was measured against ten criteria and a submission was made following review by the Quality Committee where the Trust was able through, a robust and transparent process deliver against nine of the ten criteria. She advised that the maximum rebate would be £1m; however this would be adjusted downwards if any of the criteria were not met.

The Director of Finance reported that following the submission, the Trust received notification from NHS Resolution that as the Trust could not deliver against all ten criteria it would receive no rebate at all, it would however receive £174k in relation to the delivery of an action plan to achieve the outstanding action. The Director of Finance advised that she would continue to challenge the decision through the regulators as the decision NHS Resolution had reached had moved away from what had originally been set out in the guidance. The Chair commented on the decision from NHS Resolution stating that the Trust had always been straight and transparent as an organisation and had been so when providing the submission. He supported the need to continue to challenge the unjust decision. The Medical Director advised that there was a need to understand how other service providers had been able to be compliant against all ten criteria's as he was surprised that they had evidence to back this up. The Director of Finance supported the comment and advised that a number of the trusts that had delivered all ten, also had CQC inspection actions against them, it was therefore be a concern that they are able to show they could deliver all ten.

The Director of Finance reported on the cash position and advised on the repayment of £5.6m loans that had resulted in a £50k interest payment saving in year. She reminded the Board that the Board decision to repay the loan had been agreed out of meeting.

The Director of Finance advised on the discussion that she and her team was having with Liverpool CCG regarding the 2019/20 commissioning requirements, in particular whether a new acting as one contract would be put in place.

The Chair thanked the Director of Finance for presenting the Financial Report & Dashboard Period 4 2018/19 which was noted and reiterated the Board support in challenging the NHS Resolutions decision.

234 Future Generations

The Chief Executive provided an update on the discussion that had taken place with trade unions, councillors and MPs and reported on the continued support from the staff for the Future Generations' strategy and clinical case for change.

The Chief Executive advised on the visit of Richard Barker, NHS England and reported on his understanding of the clinical needs of the Trust following his meeting with clinicians, during the visit. She advised that he had commented on the staff that had been very able in articulating why the Trust needed to make changes for the future needs of women and babies. The Chief Executive referred to the letter she had received from Richard Baker following the visit in which he provided some challenging but helpful comments. The Medical Director advised that there was a real need for the

Trust to be fit for the future so that it can deliver the best provision of healthcare for the women of Liverpool. He felt it was an exciting prospect to have a new state of the art building that provided the best possible care for women in a build that would be fit for purpose.

The Chief Executive in response to a question from Ian Knight advised that it was still not known when Liverpool CCG would be able to go out to public consultation, however she understood that the Trust would be advised on the decision regarding funding in November and at that point, if successful, the CCG would be able to proceed to public consultation.

The Chair thanked the Chief Executive and Medical Director for the update which was noted.

235 Review of risk impacts of items discussed

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

- The Patient Story highlight the need to access multiple services not provided at the Trust currently but would be available if the Trust was located on the University Health Campus.
- The need to take on board the requirements that embedded equity and diversity in all that the Board and staff do day to day and being able to demonstrate that it was embedded.
- Continued risk of being able to recruit consultant staff that were of the calibre needed so that the Trust could continue to deliver the highest quality of services to patients using the services of the Trust.
- The risks on non-delivery of the CNST re-adjustment arising from the submission to NHS Resolution, and the wider risks of not delivering 2018/19 CIP and the non-recurrent nature of its mitigation.
- The future commissioning intentions for an "acting as one contract" for 2019/20.

236 Any other business & Review of meeting

The Chair reported on the resignation of David Astley and thanked him for his support and support to the Board and Trust over the tenure of his appointment. The Chair advised that he would be missed both as a board member and contributor to the debate and discussion at the Board and board committees but also that he would miss David's advice and support

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

Date of next meeting

The Chair reported that the next meeting of the Board in public would be 5 October 2018.

Agenda Item 2018/253

TRUST BOARD
5 October 2018 Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
1 June 2018	2018/167	The acting Director of Nursing and Midwifery to provide an update on progress made on the implementation of the National Maternity Review continuity of care pathway at the Board meeting on 2 November 2018	Director of Nursing and Midwifery	~~2 November 2018~~ now 7 December 2018	The target date for delivery of this update has moved to 7 December 2018.

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

Agenda Item	2018/255

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Chief Executive Report**
DATE OF MEETING:	Friday, 05 October 2018
ACTION REQUIRED	**For Noting**
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	
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. *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. ……* ☒
	3. *The Trust is not financially sustainable beyond the current financial year……* ☒
	4. *Failure to deliver the annual financial plan ……* ☒
	5. *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒
	6. *Ineffective understanding and learning following significant events……* ☒
	7. *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒
	8. *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒
	9. *Inability to deliver the best clinical outcomes for patients……* ☒
	10. *Potential for 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:-….)***	***Board is asked to note the content of the report.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable		
	Date of meeting			

Executive Summary

In this briefing for the Board I aim to summarise recent and relevant information which relates to:

Firstly, in Section A, news and developments within the Trust itself that is not already reported elsewhere.
Secondly, in Section B, news and developments within the immediate health and social care economy.
Thirdly, in Section C, other news and developments within the wider national health and social care economy, including regulatory developments.

Further information is available on request on any of the topics covered by the report.

Kathy Thomson.
Chief Executive.

Report

SECTION A - INTERNAL

Merseyside Awards: Annmaria Ellard, Midwife has been listed in 30 of the most influential and inspirational women changing the face of Merseyside - https://www.liverpoolecho.co.uk/news/liverpool-news/30-most-influential-inspirational-women-15171582. The Article congratulates Annemarie who works at the Trust providing support and compassion to women using our services who had lost a baby through miscarriage. Congratulations to Annmaria in being acknowledged in this award.

Butterfly Awards 2018: Terri Thompson, Neonatal Nurse has been shortlisted in the Butterfly Awards, voting opens on 1st October 2018.

Service of Remembrance: The Service of Remembrance organised by the Honeysuckle team will be held on Wednesday 10th October 2018 at St Georges Hall. This is a ticketed event this year and only those with tickets will be able to attend. Tickets are available from our website www.liverpoolwomens.nhs.uk/remenbranceservice2018.

Mental Health Awareness Day 10 October 2018: The Trust Wellbeing team are holding a mental awareness event during the day on 10 October 2018.

Gynaecology: A new Clinical Director (CD) for Gynaecology has been appointed, Andrew Drakeley. This post will be key to the good functioning of the new Gynaecology Division, which will include Reproductive Medicine, Gynaecological Cancers, Urogynaecology and Benign Gynaecology. The new CD has set about responding to the challenge posed to our gynaecological services by recruitment and retention problems at Consultant level.

Cheshire and Mersey Women and Children's Vanguard: The Medical Director presented the clinical case behind the Trust's Future Generations strategy to the Cheshire and Mersey Women and Children's Vanguard this month, asking for their explicit support as the Trust seeks priority status in the government's upcoming capital programme for the NHS. A statement of support was secured from the Vanguard.

Media Interest: There was some media interest around the Future Generations strategy, coinciding with the Labour party Conference in Liverpool this week. Local TV, newspaper and social media outlets carried stories relating to the strategy, featuring the MD, the Deputy MD and the Trust's Associate MD, all of whom are Consultants in clinical practice. Invitations were made to the Labour Party's leader and the Shadow Secretary of State for Health for one to one discussions around the Future Generations strategy, but these invitations ultimately were not taken up.

Annual Members Meeting: the next Annual Members meeting of the Trust is to be held on 13 October 2018. Notifications of the meeting will be issued to members of the public in the usual way.

Staff Coast to Coast Challenge: the Weekend of 22 and 23 September saw 18 staff members from areas such as Purchasing, Estates, Finance, Communications, IT, Community Midwives and Theatres taking part in the Coast to Coast cycle ride. Staff came together as one team to complete the Coast to Coast, from Whitehaven to Tynemouth, over three days, which was a personal challenge for each one of them. Whilst coming together to complete the challenge they raised money for Liverpool Women's Charity along the way and have raised to date £1,245.00. The just giving page is still open if you have not contributed: https://www.justgiving.com/fundraising/liverpool-women-s-c2c

Operation Christmas Child 2018 : It's time to think about collecting children's gifts and necessities to fill a show box for children around the world. A small shoebox can have a big impact. What goes into the box is fun, but what comes out of it is a treasure for a child who will likely never receive anything like this again and it will show them they are cared for by "friends" from around the world. Flat packed shoe boxes have been purchased that do not need wrapping so if this encourages anyone to fill one please contact Chris Website on ext 4186 or email chris.webster@lwh.nhs.uk to collect a box. Leaflets can be collected from reception and are vital to guide you in what to do, how and when. We aim to send the boxes on November 12th so please have them back to the Macmillan office in gynaecology outpatients prior to this.

Manchester IVF Services: CCG's in Manchester have tested the market for willing providers for IVF services in Manchester and surrounding areas. Representatives from the Trust and Wrightington, Wigan and Leigh NHS FT attended a fact finding meeting with the Commissioners and have been informed of the commissioners' intention to tender the services in November 2018 for a start date in the first quarter of 2019/20.

SECTION B – LOCAL

Links with the Royal Liverpool Hospital: The Medical Director remains active on the Royal Hospital site. This month, direct links have been facilitated with Bowel Surgeons at the Royal (with respect to joint operating in complex benign gynaecology cases), Anaesthetists at the Royal (with respect to the formation of new joint consultant posts) and the Medical Education teams across both sites, so that closer co-operation can be achieved towards the common goal of improving care for the women we serve.

2018/256

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 24 September 2018

1. Was the quorate met? Yes

2. Agenda items covered

~ Operational Performance Month 5 2018/19 including RTT and Cancer Targets: The Committee received Month 5 Performance Dashboard and noted the contents of the report. It was noted that the 18 week RTT and Cancer recovery plans have improved and the backlog queries have also significantly reduced. However, due to recent further reductions in capacity there are delays and risks in the recovery of these targets back to compliance. The Committee received a revised projection that the RTT target would not be achieved until the end of Quarter 4 and that although the cancer 62 day target will improve, it is not expected to be compliant in this financial year. The Committee noted that the recovery plans were reliant on consultant appointments and the use of the capacity of an independent provider.

~ Finance Performance Review Month 5 2018/19 including CIP: The Committee received Month 5 2018/19 finance position and noted that the Trust was on target to deliver the control total for the year despite the known risks to the cost improvement programme and other known cost pressures. The underlying position going into future years was cause for concern.

~ Preparing for 2019/20 Commissioning Negotiations: Right Size
The Right Size Project is progressing and clinical engagement remains key. The Committee received an update on work carried out and outcomes delivered to date.

~ Strategic Outline Case Update: The Committee received a status update.

~ Electronic Patient Records (EPR) Update: Delays to the EPR programme were highlighted to the Committee's attention. The Committee was briefed on the challenges faced, and of the actions being taken and proposals to move forward. The Committee confirmed that the EPR BAF risk remained at the highest score of 25.

Neonatal Single Services Update: The Committee received an update on the progress of delivery of the single neonatal service; in particular it noted the governance arrangements set out in the MoU were being implemented with the formation of the Neonatal Partnership Board and the Neonatal Partnership Delivery Group.

~ Neonatal Redevelopment Project Update : The Committee noted that the fifth Project Board had taken place and considered the Project Report Summary. The project was on track in terms of design and the risks and the cost were being managed to bring the total spend within the £15m capital spend budget.

~ International Business Health Consultancy: The Committee received a position update on the prospect of consultancy work in China following the MOU the Trust signed in October 2017 with the Xi'an Taikang Hospital Management Company.

- Sub Committee Chairs reports received
  - Turnaround and Transformation Committee held 6 and 20 August and 3 September 2018
  - Emergency Planning Resilience and Response Committee held 6 August and 3 September 2018
  - Information Governance Committee held 27 July 2018
  - Digital Hospital Sub-Committee held 27 July 2018

  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 agreed that there would be not changes made to the BAF risk scores

4. Issues to highlight to Board

- EPR Programme delivery continued to be at risk.

5. Action required by Board

- None

Jo Moore
Chair of FPBD

2018/257

Board of Directors

Committee Chair's report of Quality Committee meeting held 24 September 2018

1. Was the quorate met? Yes

2. Agenda items covered

~ Subcommittee Chairs Reports:
- Safety Senate held 10 August and 14 September 2018
- Effectiveness Senate held 20 July and 17 August 2018
- Experience Senate held 11 September 2018
- Corporate Risk Committee – 19 July 2018

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

~ Quality & Regulatory Improvement Requirements: The Committee noted and reviewed the contents of the update as to progress made with the action plan put in place following the receipt of the CQC Inspection report. It was noted that further focussed work is required with the service leads to ensure that robust local action plans are developed to support the completion of the recommendation.

~ Security Management Annual Report 2017/18. The Committee received the Annual report on how it has met the standards set by NHS project in relation to security management and local priorities. It received and approved the report and supports the priorities outlined for 2018/19.

~ Monthly Quality Performance Review M5 2018/19
The Committee received Month 5 Performance Dashboard and noted the contents of the report. It was noted that the 18 week RTT and Cancer recovery plans have improved and the backlog queries have also significantly reduced. However, due to recent further reductions in capacity there are delays and risks in the recovery of these targets back to compliance. The Committee received a revised projection that the RTT target would not be achieved until the end of Quarter 4 and that although the cancer 62 day target will improve, it is not expected to be compliant in this financial year. The Committee noted that the recovery plans were reliant on consultant appointments and the use of the capacity of an independent provider.

~ Trust Response - Review of Francis Report recommendations: The Committee was asked to take assurance from the work of its sub committees in overseeing the Trust's current compliance against each of the recommendations in the Francis report. The Committee recommended that a check should be made as to whether this needs to be reviewed on an annual basis through the Quality Committee moving forward or whether the one outstanding action could now be reviewed through different mechanism.

~ PLACE Annual Report 2017/18: The Committee considered the PLACE Annual Report 2017/18 and noted its contents.

~ Clinical Audit Annual Report 2017/18: The Committee received, noted and approved the contents of the Report. The Clinical Audit and Effectiveness Team will continue to develop the process for finalising completing audits, discussing results in the right forums, disseminating findings and monitoring actions and lessons learnt to demonstrate changes in practice continue to take effect. The committee noted the importance that lessons learned are disseminated across the Trust.

3. Board Assurance Framework (BAF) risks reviewed

The Committee reviewed the quality related BAF risks it is responsible for on behalf of the Board. The Committee noted the suggestion from the acting Director of Nursing and Midwifery that risk score for the 'patient experience' risk (2167) be reduced from 9 to 6. The Committee agreed that before it recommends a reduction to the Board that this risk is reviewed by the 'new' Director of Nursing and Midwifery and any recommendation be made to the Committee at the October meeting.

The Committee agreed, with exception to the risk 2167, all other changes were agreed.

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

None noted

5. Issues to highlight to Board

EPR Risk

6. Action required by Board

To note and agreed the Changes made to the BAF, which would be incorporated in the overarching document that would be presented to the Board at its 5 October 2018 meeting.

Susan Milner
Chair of Quality Committee

PPF Chairs Report to add

Baby Saver presentation

Agenda Item	2018/260

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Adult Mortality Quarterly Report 2018/19 Quarter 1**
DATE OF MEETING:	Friday, 05 October 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Devender Roberts – Associate Medical Director of Governance 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.*** *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. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☐ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☒ ***10.*** *Potential for 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:-….)***	***Board is asked to take assurance that there is adequate progress being made against the requirements laid out by the National Quality Board.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Quality Committee		
	Date of meeting	July 2018		

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 Quality Committee.

Key findings:

- There were 2 in-hospital expected gynaecology oncology deaths during Quarter1 of 2018-19.
- Adequate progress is being made in systems to reduce mortality through good governance.
- 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. 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.

Table 1: Obstetric Mortality

501 - OBS	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	1712	1900	0	0	0	0	0	0	0	0	0	0	3612
Rate per 1000 Discharges	0.0	0.0											0.0

Table 2: Gynaecology Mortality

502 - GYNAE	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	883	955	0	0	0	0	0	0	0	0	0	0	1838
Rate per 1000 Discharges	0.0	0.0											0.0

Table 3: Gynaecology Oncology

503 - GYNAE ONC	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	TOTAL
Total Mortality	1	1	0	0	0	0	0	0	0	0	0	0	2
Discharges	63	69	0	0	0	0	0	0	0	0	0	0	132
Rate per 1000 Discharges	15.9	14.5											15.2

Out of hospital deaths 2017-18 Quarters 1

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 that commenced February 2018.

There were no reported out of hospital deaths for quarter 1.

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

Reporting Quarter	2016-2017		2017-2018		2018-2019	
	In-hospital	Out-hospital	In-hospital	Out-hospital	In-hospital	Out-hospital
Q1	3	-	1	2	2	-
Q2	2	-	0	-	0	-
Q3	3	-	0	-	0	-
Q4	1	-	1	-	0	-
Total	**9**	**-**	**2**		**2**	
		0		2		0
Overall total deaths	**9**		**4**		**2**	

2. 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 1		
	Maternity	**Gyneacology**
No of Adult Deaths	0	2
No of Mortality Reviews completed	0	2
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

3. 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

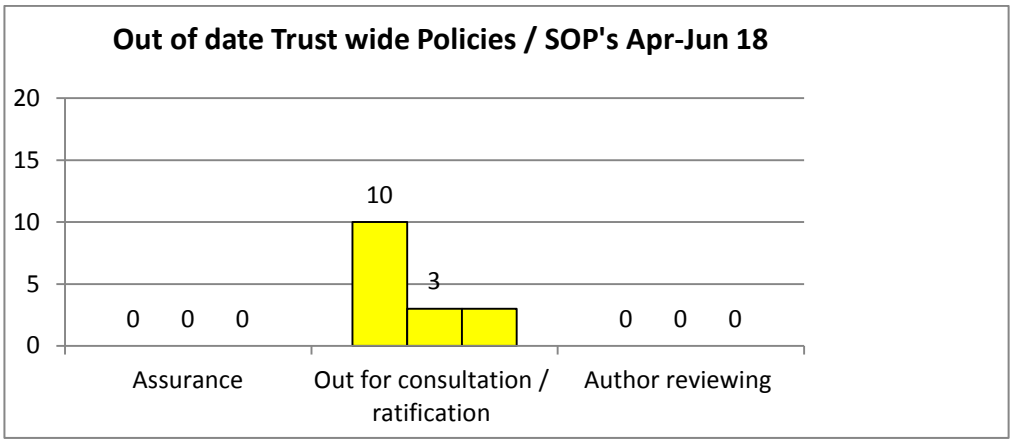
- To review all shared learning and any gaps / omissions to be addressed as service evaluation of the department. And a process to ensure shared learning takes place and is then evaluated as how effective it has been.
- There was no clear evidence if shared learning had all been completed from the original 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.

4. Prevention – What does Liverpool Women's do to Mortality

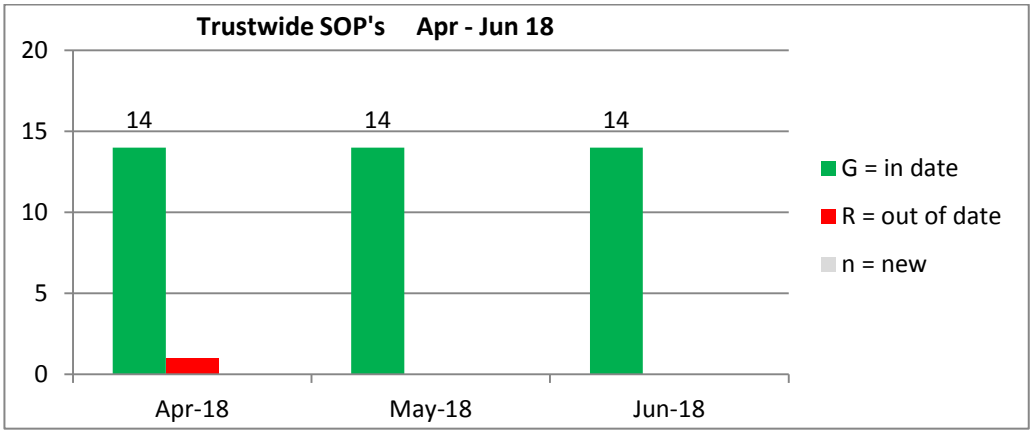
The Trust guidelines and SOPS have undergone scrutiny, merging and updating as they have migrated onto a new on-line easy access intranet for clinical staff to access 24/7. The phase commenced with Maternity department during 2017/18, this has been successful; it is now planned to commence work to roll out for gynaecology and neonatal departments for all their guidelines and SOPs to be fully accessible on line.

Trustwide

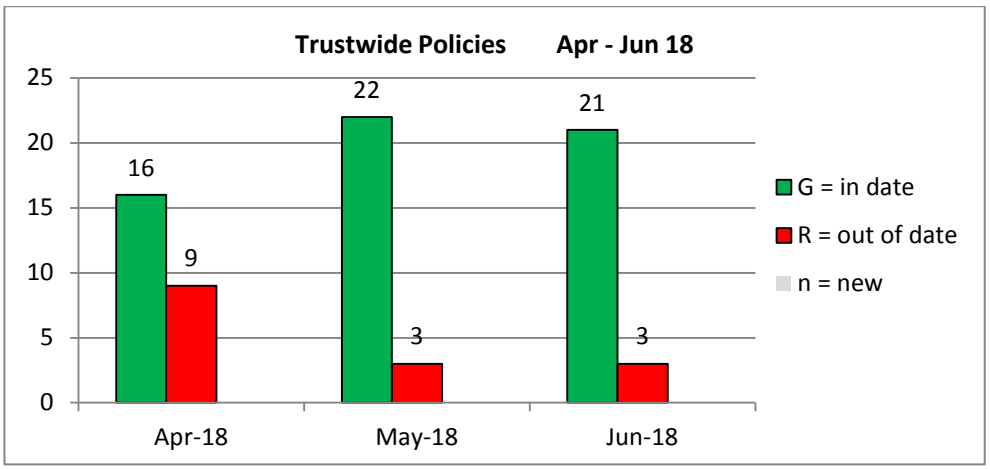
a) Trust wide policies, guidelines and SOPS



b) The chart below shoes the number of Trustwide SOPs for each month of quarter 1, there are currently no out of date SOPs

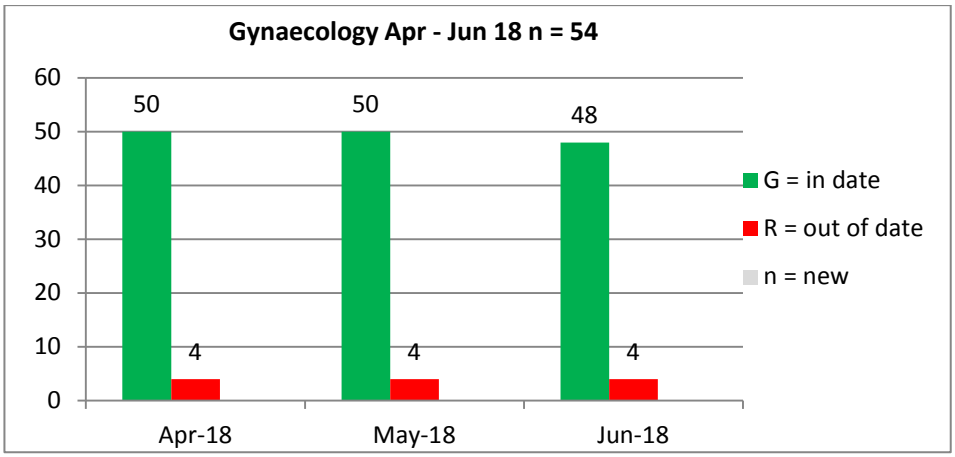


c) The chart below shoes the number of Trustwide Policies for each month of quarter 1, there are currently 3 out of date policies awaiting completion and ratification



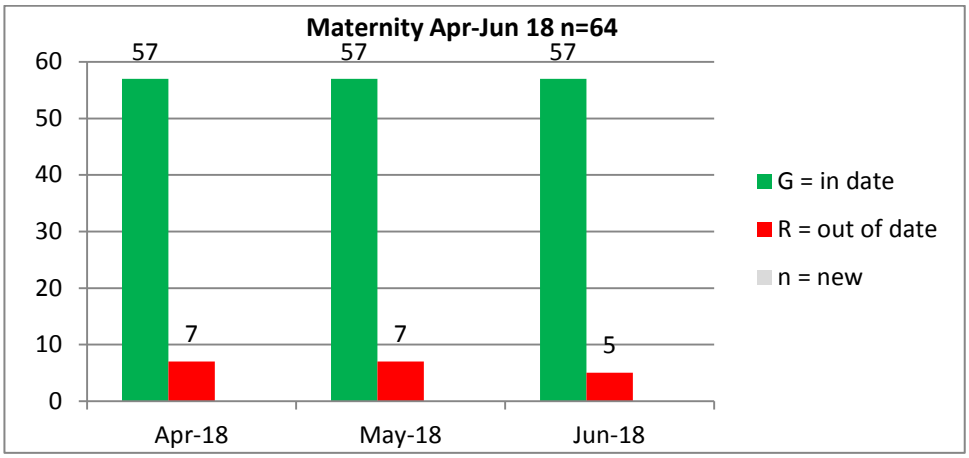
Gynaecology

The chart below shows the number of Gynaecology Policies for each month of quarter 1, there are currently 4 out of date policies awaiting completion and ratification



Maternity

The chart below shows the number of Gynaecology Policies for each month of quarter 1, there are currently 5 out of date policies awaiting completion and ratification



5. 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
- Sepsis
- Venous thromboembolism

The below table is The Annual Audit Programme for 2018 – 2019.

Adult Mortality – Clinical Audit Q1

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. (Audit Green 1 on audit dashboard). Re-audit scheduled to start late 2018.
	Bedside transfusion (including consent)	Received report including action plan. Results have been presented at the Hospital Transfusion Team meeting in May18. Evidence of actions complete received. As a result of this audit there has been increased emphasis on the need to: • ensure mandatory training is up to date • document the finish time of transfusion • ensure within junior doctors training sessions that they are aware that consent must be sought from the patient where possible. (Audit Complete).

		Re-audit scheduled to start late 2018 – this will also capture data in relation to TACO and NICE QS138 & NG24.
	SHOT NCA of TACO prevention Require evidence presented	Received report including action plan. Results have been presented at the Hospital Transfusion Team meeting Jan-18 and the Grand Round Mar-18. Awaiting evidence that all actions complete. (Audit Green 1 on dashboard). Re-audit data will be captured as part of the annual Bedside transfusion audit.
	National Comparative audit of blood transfusion programme – Audit of Massive Haemorrhage Autumn 2018	National Audit due to commence Sep-18.
Psychiatric disease	Antenatal Perinatal mental health management and outcome at Liverpool Women's Hospital	Audit registered. Data collection in progress. (Audit Amber on dashboard).
	Trust wide Mental Health	Audit to be completed in Qtr3 for submission Qtr4.
Sepsis	Audit of the management of pregnant women with asymptomatic bacteriuria at booking visit *(Previously titled: "Maternal and Congenital sepsis")*	Received report including action plan. The audit results showed non-compliance with the Standard Hospital Contract 2017; therefore a care pathway to take away reliance of GP's to repeat a booking of MSSU is to be devised. Once this is implemented a re-audit will be

		registered. (Audit Green 1 on dashboard).
	SEPSIS bundle – Maternity	Data being captured via NUMIS. (No clinical 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. (No clinical audit required).
Venous thromboembolism	Assess LWH Gynaecology admissions against NICE QS 03 – VTE in Adults; reducing the risk re-audit	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. The delay was due to the PENS Lead at RLUH leaving and being replaced. Contact with the new Lead is in progress and this action is planned for implementation very soon. (Green 1 on audit dashboard). Further Re-audit scheduled to start late 2018.
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.
Cardiac Disease		

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 1		
	Maternity	**Gyneacology**
No of Adult Deaths	0	2
No of Mortality Reviews completed	0	2
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 are going to perform a deep dive on the two unexpected deaths in 2016/17 in order to provide assurance to the Board.

8. Horizon Scanning

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

Period: Q1 March 2018 – May 2018.

Sources: CQC, NCEPOD, 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. 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 Committee regarding governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust.

Agenda Item	2018/261

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Neonatal Redevelopment Project**
DATE OF MEETING:	Friday, 05 October 2018
ACTION REQUIRED	**For Approval**
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.*** *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. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***4.*** *Failure to deliver the annual financial plan* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☒ ***6.*** *Ineffective understanding and learning following significant events* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ ***9.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***10.*** *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):	5. This report will not be published under the Trust's Publication Scheme due to exemptions under S43(2) of the Freedom of Information Act 2000, because such disclosure would be likely to prejudice the commercial interests of the Trust			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to note the progress made to date and on the recommendation of the Neonatal Project Board following its meeting on 4 October 2018 that the Guaranteed Maximum Price (GMP) of £14.74M is approved.			
PREVIOUSLY CONSIDERED BY:	**Committee name**		***Choose an item.*** Or type here if not on list: Neonatal Project Board	
	Date of meeting		Thursday, 04 October 2018	

Report

1. Project Progress

The Project Board will consider the Project Report Summary No.9 (28th September 2018) on the 4 October 2018 and will provide a recommendation to the Board at its meeting on 5 October 2018, with regard to the Guaranteed Maximum Price (GMP).

This project report noted the following **key achievements**:-

- The Project Team have completed a review of the GMP over the last few weeks. Further, work to incorporate accepted value engineering proposals into the GMP offer have been completed with agreement with the Trust. The GMP offer has now been issued to the Trust for approval.
- Works have commenced to Phase 1a of the Project in the Rosemary and Catherine Suite.
- Some minor additions have been approved which relate to legacy fire protection and existing maintenance and engineering services defects as part of the works (costs to be covered by backlog maintenance funds).
- Interserve has taken possession of the site cabins in front of the outpatient department entrance which were previously housing the IT team.
- Approval of the main project planning application is due to be issued via Liverpool City Council on 5th October 2018; draft conditions have been issued none of which are onerous.

- A separate planning application has been issued to Liverpool City Council for ambulance canopy and drop off relocation.

Key Issues

- The Stage 4 NICU cost plan is totalling £14.74m (incl VAT/VAT reclaim) following completion of the GMP exercise.
- The completion date for the NICU Project has been adjusted to 13th July 2020 as part of the GMP offer. The programme elongation is due to the 5 weeks delay in approval of the Phase 1a Enabling Scheme, and a further 6 weeks due to the finalisation of the detailed programming from the Interserve supply chain.

- The Non Project costs for site wide infrastructure resilience has a total value of £1.244M and is planned into the next two years capital backlog maintenance budgets.

Communication Plan

The project has already been communicated widely across the Trust with individual details of phase 1a being launched week beginning the 3rd September 2018 as a communication brief and the main focus of " In the Loop" on the 14th September 2018. A long term communication plan for the duration of the building work is due to be presented to October's Project Board that will cover the 6 phases of the build.

2. Conclusion

The project has now concluded the design phase with a Guaranteed Maximum Price of £14.74M and related non-project costs of £1.244M being managed over two financial years from backlog maintenance.

The Project completion date is the 13th July, 2020.

3. Recommendation

The Board is asked to note the progress made to date and on the recommendation of the Neonatal Project Board following its meeting on 4 October 2018 that the Guaranteed Maximum Price (GMP) of £14.74M is approved.

Jeff Johnston
Director of Operations
28th September 2018

Agenda Item	2018/262

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**
DATE OF MEETING:	Friday, 05 October 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	**Caron Lappin, Director of Nursing and Midwifery**
AUTHOR(S):	Caron Lappin 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.*** *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. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☒ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services..* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐

	WELL-LED *- the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☒	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to note: • The 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.
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 June 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 the safe staffing exception report related to staffing levels, incidents and red flags which are triangulated with a range of quality indicators for both nursing and midwifery.

2.0 Safer staffing exception report

The safer staffing fill rate (appendix 1) provides the established versus actual fill rates on wards split by registered and unregistered staffing hours and by day and night shifts. 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 has been developing a ward accreditation system which is required to support the collection of quality indicators alongside real time patient safety flags. This work is currently being reviewed by the new DON&M It is envisaged that this work will need to be reviewed, adapted and then re launched across the organisation.
- ACE incident submissions related to staffing and red flags, are monitored daily at the huddle
- Nurse sensitive indicators demonstrate outcome for patients measuring harm these include;
    - 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
    - Cases of Clostridium Difficile (CDT)
    - In line with the National Quality Board 2016 the trust publishes nursing and midwifery staffing data on a daily basis at entrances to wards, staffing data is also submitted on a monthly basis through a unify submission to the NHS choices site.

2.1 Summary of fill rates

The inpatient wards have been able to maintain fill rates during the month of June and July 2018.

June 2018 the average fill rate for registered staff was greater than 90.9% day time, 93.5% night time, and the average fill rate non registered staff 82.9% day time, 86.7% night time. Maternity division displayed the lowest fill rate due to a seasonal spike in short term sickness, coupled with long term sick and maternity leave, agreements in place to recruit to cover maternity leave, recruitment plans underway to address this shortfall across maternity services.

July 2018 the average fill rate for registered staff day time, 102.68%, 96.48% for unregistered staff, the average fill rate for registered staff night time 101.58%, unregistered 93.46%, maternity displayed the greatest increase in fill rates for registered staff due to recent recruitment drives within maternity services.

Safe staffing for each ward is assessed on a daily basis by the relevant Divisional Matrons. The duty manager is responsible for the evenings and weekends within the divisions and, the on call senior manager has the responsibility for ensuring safe staffing of all ward areas across the Trust.

2.2 Red Flags

August 2018 – Red Flags

There were a total of 16 incidents, reported under the Nursing/Midwifery red flag staffing criteria:

- 4 incidents relating to gynaecology involving staffing shortages, theatre overruns impacting on patient cancelations and a full emergency list requiring a second theatre to be opened.
- 6 incidents relating to midwifery involving staffing shortages, missing documentation and missed prescription.
- 6 incidents relating to neonates involving staffing shortfalls, missed medications and issues around capacity and being on red as the unit was full.

Investigations into these concluded that staffing levels and skill mix were safe at the time and did not contribute directly to any incidents. All incidents were reviewed within the recommended timeframes and action plans commenced if appropriate.

3.0 Actual vacancies at LWH

Aug-18

Registered Nurse	Budget	Actual	Vacancy	Bank used
substantive	348.60	309.97	38.63	10.72

Registered Midwives	Budget	Actual	Vacancy	Bank used
substantive	282.89	268.23	14.66	7.05

Non Registered	Budget	Actual	Vacancy	Bank used
substantive	162.45	154.41	8.04	9.55

There are presently within the HR recruitment process, 17 midwives in conditional offer, with 15 of these with a booked start date, 2 to receive start date shortly. Registered Nurse recruitment numbers obtained through TRAC, 27.84WTE with 14.84 in conditional offer, no start date noted, 13 WTE with conditional offer and a booked start date.

Retaining staff is a key element in addressing the workforce position and the preceptorship of registered nurses and registered midwives is currently being addressed to support all new starters.

Further work is planned over the next 6 months to improve the quality of the staff rosters via the Health Roster system which will then provide more detailed accurate information that will assist in supporting safer staffing across the organisation.

4.0 Summary

During the month of August 2018 all wards were considered safe with low/no levels of harm and positive patient experience across all inpatient areas indicating that safe staffing has been maintained.

There has been a noted decrease in fill rates with central delivery suite, in this reportable period, due to long term sickness, a spike in short term sickness, maternity leave and vacancy rate. Recruitment within maternity is ongoing to address vacancy and maternity leave, the clinical KPI's for high risk maternity care and midwifery indicators such as breast feeding and immediate skin to skin contact have seen no decline in performance, due to maternity's ability to review staffing, directing staffing to the area of most clinical need.

Gynaecology will remain the focus for monitoring recruitment and reporting of incidents ensuring that red flags are discussed and acted on with the Gynaecology Head of Nursing and Management team. Neonatal activity will be monitored in regards to declaring red on the unit, which has an impact on increased transfers of women out of LWH. It initially appears that this is due to physical capacity rather than staffing shortages.

5.0 Recommendations

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

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 (%)
Aug-18	Gynaecology	90.8%	102.75%	96.81%	103.23%

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 (%)
Aug-18	Induction&Delivery Suites	80.4%	82.8%	85.2%	87.1%
	Maternity Base	87.9%	77.6%	90.8%	100.0%
	MLU & Jeffcoate	69.9%	100.0%	72.6%	100.0%
	Maternity Total	80.3%	81.9%	83.9%	94.5%

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 (%)
Aug-18	Neonatal Care	110.1%	87.1%	107.7%	85.5%

The calculation for Care Hours per Patient Day (CHPPD) is provided below;

CHPDD= Total number of registered and unregistered staff hours
Number of occupied beds at 23:59hrs

Registered Midwives/Nurses	
	Aug-18
Gynaecology Ward	4.1
Delivery & Induction Suites	21.6
Maternity Base	4.4
MLU & Jeffcoate	27.2
Neonates (All)	11.0

Care Staff	
	Aug-18
Gynaecology Ward	3.0
Delivery & Induction Suites	4.3
Maternity Base	2.2
MLU & Jeffcoate	6.4
Neonates (All)	1.1

Overall	
	Aug-18
Gynaecology Ward	7.1
Delivery & Induction Suites	25.8
Maternity Base	6.6
MLU & Jeffcoate	33.6
Neonates (All)	12.1

Reporting Month Staffing Levels: **Aug-18**
Reporting Month CHHPD: **Aug-18**

Standard	**Patient Safety is delivered through consistent, appropriate**				
Ward	RN/RM		Non Registered		
	Fill Rate Day%	Fill Rate Night %	Fill Rate Day%	Fill Rate Night %	Total Workforce CHHPD
Delivery & Induction Suite	80.44%	85.16%	82.80%	87.10%	25.8
Mat base	87.90%	90.78%	77.55%	100.00%	6.6
MLU & Jeffcoate	69.89%	72.58%	100.00%	100.00%	33.6
NICU	110.08%	107.66%	87.10%	85.48%	12.1
Gynae Ward	90.83%	96.81%	102.75%	103.23%	7.1

Day		Night	
Average Fill Rate	Average Fill Rate	Average Fill Rate	Average Fill Rate
Registered Nurses/Midwives	Care Staff	Registered	Care Staff
90.7%	87.8%	92.8%	93.5%

	CHPPD
Registered Nurse/Midwife	9.6
Care Staff	2.4
Overall hours	12.0

Ward Name	**Aug-18**
Gynae 1&2	7.1
Mat Base	6.6
MLU	33.6
Delivery Suite	25.8
NICU	12.1
Total CHPPD	**12.0**

Agenda Item	2018/263

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Performance Report month 5**
DATE OF MEETING:	Friday, 05 October 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.*** *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. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☐ ***10.*** *Potential for 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):	*Choose an item.*	
RECOMMENDATION: *(eg: The Board/Committee is asked to:-….)*	***To note the content and be assured that every effort is being made to improve access targets***	
PREVIOUSLY CONSIDERED BY:	**Committee name** **FPBD** **Quality committee**	*Choose an item.* Or type here if not on list: *Click here to enter text.*
	Date of meeting **24/09/18**	*Click here to enter a date.*

1. Introduction

The Trust Board dashboard is attached in **Appendix 1** below.

2. Performance

The four areas to highlight to the Committee are as follows:-

2.1 NHSI Targets – Access Targets including Cancer targets

2.1.1 18 weeks RTT – 52 week breaches

The Trust has reported the RTT 18 week target as 88% for July with a finalised figure for August at 87%. As reported in Board in September reduced consultant capacity will delay the recovery of the target. Since that meeting there has been further reduction in clinical capacity with regard to locum consultant resignation, long term sickness of a consultant and a phased return for another consultant. It is also evident and expected that the newly appointed consultants do not provide the same level of activity as there more experienced colleagues.

A revised projection has been completed based on these factors and also assumptions on timescales to recruit to consultant vacancies both in terms of permanent and temporary basis. It should be noted that there is a risk that not all posts will be recruited which again will impact the recovery. The management team is exploring every possible source for clinical workforce to increase capacity in the short and long term.

The revised projection highlights that with these assumptions the Trust should achieve compliance to the RTT by the end of quarter 4.

The number of 52 week breaches in June is 19. This has increased to 25 in July. It is anticipated that this will now start to reduce each month eventually to zero by the end of quarter 4.

With limited capacity (32 clinical sessions per week below capacity) the focus will be to continue to eradicate 52 week waiters, maintain the queue length and reduce the time to wait for new patients. The service is currently securing additional capacity for the least complex general gynaecology patients via Medinet a provider of locum consultants. This activity will be conducted at the weekends and is expected to start the second week in October on the completion of agreeing both clinical governance and contractual aspects of the arrangements.

2.1.2 Backlogs

The management of the backlog queues continues but with reduced capacity it is no longer possible to eradicate them in the previously stated timeframes. At the beginning of September, the queues were 614 for new appointments and 617 for follow up appointments. As in previous months the backlog number will increase on the first of the month as the following months patients are added. The new patients have been validated and 230 have been identified as potential for weekend via the Medinet arrangements. The use of other local NHS providers has been explored and is not viable due to the lack of capacity across . In September one new locum will join the team and recruitment of another locum is being pursued both these actions will help to stabilise the position.

See projections in appendix 2 that predicts RTT and queue compliance and improvement by end of Q4.

2.1.3 Cancer Targets

All figures for August remain provisional until final sign off via Open Exeter (beginning July 2018) and potential of further impact of diagnosed patients and shared breach allocations with other Trusts.

Confirmed performance for **July** 2018 was as follows:-

- 2 week wait – **Target 93%** - **performance 99.60%** (224 out of 225 patients seen within 2 weeks) –**achieved**
- 31 days DTT – **Target 96% - performance 88.6%** (39 out of 44 patients treated within 31 days of decision) – marginally failed 96% standard due to availability of operating time and patient availability.
- 62 days – **Target 85% - performance 61%** (12.5 out of 20.5 patients treated within 62 days of urgent referral.)– significant failure due to delays in diagnostics meaning late diagnosis on pathway and complexity of patients requiring input from outside the Trust before being optimised for surgery. This is the post breach reallocation position, and includes 3 patients who breached 104 days (RCA undertaken.)
- 62 day upgrade – **local Target 85% - performance 87%** (6.5 out of 7.5 patients treated within 62 days of upgrade decision) – reasons as above.

Performance against all of the above cancer standards **provisional August 2018 position:-**

- 2 week wait **– 94%** (186 out of 198 patients seen within 2 weeks) – **achieved.**
- 31 days DDT – **86%** (18 out of 21 patients treated within 31 days of decision) – still **marginally short** of the 96% standard as a result of limited operating session availability and patient availability.
- 62 days – **27.7%** (1.5 out 5.5 patients treated within 62 days of urgent referral). This is subject to change as a result of reallocation between Trusts and delays in diagnostic reporting confirming or excluding a cancer diagnosis of patients treated in month.
- 62 day upgrade – **100%** (3 out of 3 patients)

As reported previously, the key indicators are expected to reach compliance targets in the following timeframes:-

2ww – April 2018 – **achieved.**
31 days – June 2018 – **not achieved**
62 days – October 2018 – as per board report and trajectories at appendix 1 this is not achievable in 2018/19.
62 day upgrade – July 2018 **- achieved**

Patient pathways are now being pro-actively managed and additional capacity made available were possible. The transformational work in cancer continues but limited capacity within LWH for hysteroscopy is causing delays in diagnosis and therefore the 62 day target. The service is working more closely with external providers to access to specialists investigations and opinions.

This has resulted in 3 patients breaching the 104 days target for definitive treatment. All of these patients have had their pathways reviewed which concludes in all cases a mixture of lack of capacity and the complexity of the individual care.

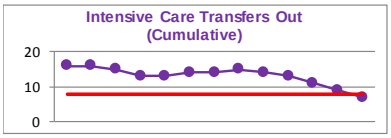
In summary , the key challenges are shortages in consultant manpower and the complexity of patients covered by the 62 day standard who require pre-operative intervention that is not covered within LWH's portfolio of services (pathology, echo, MRI, CT) plus reduced internal capacity for hysteroscopy at LWH.

The service has responded quickly to rectify the performance on waits for first appointment. The service is confident that 2 Week wait and 31 day standards will be achieved in line with the above trajectory. However, to deliver against the 62 day pathway will require pathway redesign and agreed ways of working with partners, which will take some time to address. The new clinical Lead for cancer is working closely with the CCG and the management team to manage referrals and improve the pathways.

2.1.4 Intensive Care Transfers 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 7 patients, the group consider the transfers to be appropriate. This is the lowest number of transfers in the year and reflects the reduced activity over the summer holiday period and reduced activity due to capacity.

Intensive Care Transfers Out (Cumulative)	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Actual	16	16	15	13	13	14	14	15	14	13	11	9	7
Target	8	8	8	8	8	8	8	8	8	8	8	8	8



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

3 Conclusion

The 18 week RTT and Cancer recovery plans have improved and the backlog queues have also significantly reduced. However, due to further reductions in capacity there are delays and risks in the recovery of these targets back to compliance. It must also be recognised that recovery plans assume that consultant appointments will be made in October and that the service utilise the capacity of an independent sector provider.

4 Recommendation

The committee is requested to note the contents of this report.

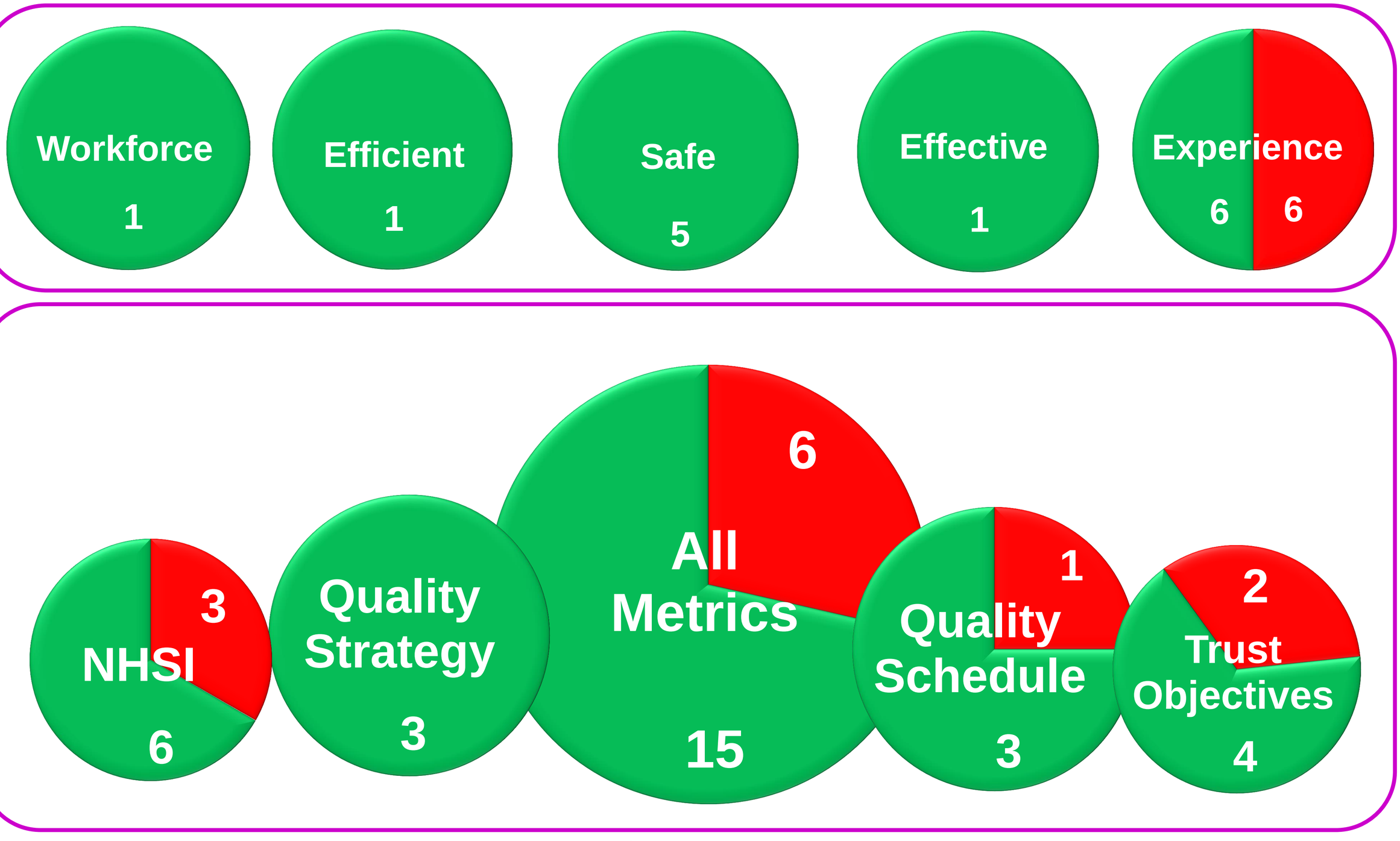
Appendix 1 – Scorecard

Performance Dashboard TB - Augu

Performance and Information Department
Performance Team

Liverpool Women's NHS Foundation Trust

Performance Report for Trust Board — Month 05 - August 2019



* 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 2018/19 Month 05 - August 2019

To be EFFICIENT and make the best use of available resources

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Qtr1	Jul-18	Aug-18	Sep-18	Qtr2	Oct-18	Nov-18	Dec-18	Qtr3	Jan-19	Feb-19	Mar-19	Qtr4
Financial Sustainability Risk Rating: Overall Score	KPI087	Head of Finance	3	3	3	3		3	3										

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Qtr1	Jul-18	Aug-18	Sep-18	Qtr2	Oct-18	Nov-18	Dec-18	Qtr3	Jan-19	Feb-19	Mar-19	Qtr4
Infection Control: Clostridium Difficile (Number)	KPI104 (EAS5)	Infection Control Lead	Refer to Infection Control	Reported in separate report by Infection Control															
Infection Control: Clostridium Difficile - infection rate (12-month rolling) 1 Qtr Behind	KPI320	Infection Control Lead	Refer to Infection Control	Reported in separate report by Infection Control															
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate (12-month rolling) 1 Qtr Behind	KPI351	Infection Control Lead	Refer to Infection Control	Reported in separate report by Infection Control															
Meticillin-sensitive Staphylococcus aureus (MSSA) rates (12-month rolling) 1 Qtr Behind	KPI335	Infection Control Lead	Refer to Infection Control	Reported in separate report by Infection Control															
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) rates (12-month rolling) 1 Qtr Behind	KPI336	Infection Control Lead	Refer to Infection Control	Reported in separate report by Infection Control															
Never Events	KPI181	Head of Governance	0	0	0	0		0	0										
NHSE / NHSI Safety Alerts Outstanding	KPI193	Head of Governance	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-18	May-18	Jun-18	Qtr1	Jul-18	Aug-18	Sep-18	Qtr2	Oct-18	Nov-18	Dec-18	Qtr3	Jan-19	Feb-19	Mar-19	Qtr4
HR: Sickness Absence Rate	KPI101	Head of Workforce	4.5%	4.52%	3.6%	4.3%		4.1%	4.3%										

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Qtr1	Jul-18	Aug-18	Sep-18	Qtr2	Oct-18	Nov-18	Dec-18	Qtr3	Jan-19	Feb-19	Mar-19	Qtr4
Maximum time of 18 weeks from point of referral to treatment in aggregate - Incompletes	KPI003 (EB3)	Access Turnaround Manager	92%	89.41%	89.09%	87.80%		87.73%											
KPI003 Numerator				4137	4130	4238		4288											
KPI003 Denominator				4627	4636	4827		4888											
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (Before re-allocation) Final Reported Position	KPI031 (EB12)	Access Turnaround Manager	>= 85%	52.63%	34.78%	63.64%		51.52%											
KPI1031 Final Numerator				5.0	4.0	10.5		8.5											
KPI1031 Final Denominator				9.5	11.5	16.5		16.5											
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation) Final Reported Position	KPI030 (EB12)	Access Turnaround Manager	85%	52.63%	33.33%	56.76%		60.98%											
KPI1030 Final Numerator				5.0	4.0	10.5		12.5											
KPI1030 Final Denominator				9.5	12.0	18.5		20.5											
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Numbers (if > 5, the target applies)	KPI033 (EB13)	Access Turnaround Manager	< = 5	0	1	0		7											
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Percentage Final Position	KPI034 (EB13)	Access Turnaround Manager	>= 90%	N/A	N/A	N/A		100%											
KPI1034 Numerator				0	1	0		7.0											
KPI1034 Denominator				0	1	0		7.0											
Complaints: Number Received	KPI038	Head of Nursing / Midwifery	<= 15	10	4	8		6	3										

Performance and Information Department
Performance Team

Liverpool Women's NHS Foundation Trust

LWH Quality Schedule 2018/19 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-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
HR: Sickness Absence Rate	KPI101 (KPI_27)	Head of Workforce	<= 4.5%	4.52%	3.6%	4.34%	4.1%	4.3%							

To deliver the best possible EXPERIENCE for patients and staff															
Indicator Name	**Ref**	**Owner of KPI**	**Target 2017/18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
18 Week RTT: Incomplete Pathway > 52 Weeks	KPI002 EBS4)	Head Of Operations Gynaecology	0	19	20	19	25								
A&E: Total Time Spent in A&E 95th percentile	KPI012 (KPI_62)	Head of Nursing	<= 240	230	235	225	225	236							
Friends & Family Test (Upper quartile will recommend)	KPI089	Head of Nursing	>= 75%	94.6%	96.4%	98.7%	96.9%	89.9%							

LWH Quality Strategy 2018/19 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	Owner of KPI	Target 2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sickness & Absence Rate	KPI101	Head of Workforce	<= 4.5%	4.52%	3.61%	4.34%	4.09%	4.27%							

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Target 2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Never Events	KPI181	Head of Governance	0	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	Owner of KPI	Target 2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Complaints: Number Received	KPI038	Head of Nursing	<= 15	10	4	8	6	3							

Liverpool Women's NHS Foundation Trust

LWH Trust Objectives 2018/19 Month 05 - August 2019

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Deaths (All Live Births within 28 Days) All live births	KPI168	Head of Operations & Nursing Neonates	< 6.1%	0.0%	0.42%	0.28%	0.13%	0.00%							
Deaths (All Live Births within 28 Days) Booked births	KPI168	Head of Operations & Nursing Neonates	< 4.6%	0.0%	0.28%	0.14%	0.13%	0.00%							

To deliver the most EFFECTIVE outcomes

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Intensive Care Transfers Out (Cumulative)	KPI107	HDU Lead	8 per year (Rolling year)	14	13	11	9	7							

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Cancer: Patients waiting 104 days or more from referral to the first definitive treatment	KPI352	Access Turnaround Manager	0	1	3	2	3								
18 Week RTT: Admitted	KPI001	Access Turnaround Manager	>= 90%	85.3%	90.6%	93.1%	93.0%								
KPI1001 Numerator				412	465	416	436								
KPI1001 Denominator				483	513	447	469								
18 Week RTT: Non-Admitted	KPI004	Access Turnaround Manager	>= 95%	91.0%	94.6%	91.9%	90.7%								
KPI1004 Numerator				1580	1684	1551	1742								
KPI1004 Denominator				1737	1781	1687	1921								

Agenda Item	2018/264

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	Finance Performance Review Month 5 2018/19
DATE OF MEETING:	Friday, 05 October 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	Claire Scott, Head of Management Accounts Eva Horgan, 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.*** *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. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☐ ***10.*** *Potential for 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):	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:-….)***	***The Board is asked to note the Month 5 Financial Position.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee		
	Date of meeting	24/09/18		
Executive Summary				

The 2018/19 Board-approved budget set out a control total deficit of £1.6m for the year after the delivery of £3.6m CIP, and receipt of £3.6m Provider Sustainability Funding (PSF). The control total includes £0.5m of agreed investment in the costs of the clinical case for change identified in the 2018/19 operational plan, in addition to the £1.0m 2017/18 investment.

At Month 5 the Trust is reporting a year to date (YTD) deficit of £1.1m against a deficit budget of £2.3m, giving a year to date favourable variance of £1.2m. This is a sustained improvement on prior months and there is reasonable assurance that the control total will be met for the year, despite the known risks to the cost improvement program and other know cost pressures. However the underlying position going into future years remains a cause for concern. The key areas of financial performance are summarised below.[1]

	Plan	Actual	Variance	RAG
Surplus/(Deficit) YTD	-£2.3m	-£1.1m	£1.2	↑
Surplus/ (Deficit) FOT	-£1.6m	-£1.6m	£0.0	↔
NHSI Rating M5	3	3	-	↔
Cash M5	£0.9m	£6.1m	£5.2	↓
Total CIP Achievement YTD	£0.8m	£0.8m	£0.0	↔
Recurrent CIP Achievement YTD	£0.7m	£0.6m	-£0.1	↔
Capital Spend YTD	£5.5m	£3.8m	£1.7	↔

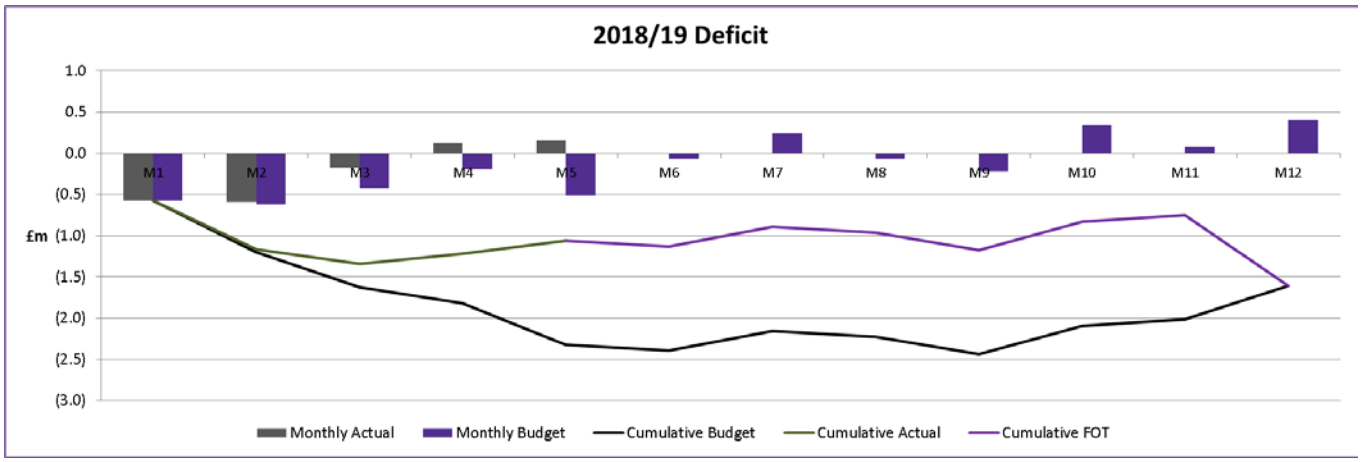
The Month 5 financial submission to NHSI is consistent with the contents of this report.

[1] NHSI Rating: Red is 4 or 5, Amber 3 and Green 2 or 1. Cash: Red is <£1m, Amber £1m-£4m and Green £4m+. Capital is not RAG rated. All other KPIs: Red is >10% off plan, Amber 0-10% off plan and Green at plan or better. Arrows denote movement from the prior month.

Report

1. Summary Financial Position

At Month 5 the Trust is reporting a deficit of £1.1m YTD against a deficit budget of £2.3m. The Trust is forecasting delivery of the £1.6m control total assuming receipt of £3.6m PSF.



In 2018/19 the Trust continues to benefit from a level of financial stability secured through the 'Acting as One' contract arrangement with main CCG Commissioners, and the NHSE block contract, which collectively account for 72% of total Trust income.

During 2017/18, the 'Acting as One' block payment was £3.8m higher than would have been received under Payment by Results (PbR). This has continued into 2018/19 with £1.6m additional income earned YTD to Month 5, than would have been earned under PbR.

Achievement of CIP remains a key risk. Failure to deliver CIP and any subsequent failure to achieve the control total would result in the loss of £3.6m PSF. The Trust has a £3.7m CIP target for 2018/19 which has been delivered at Month 5 (against the YTD plan), but there are risks to full year achievement.

2. Service Summary Overview

Whilst the Trust-wide financial position remains ahead of plan YTD and is forecast to achieve full year, there are some areas of divisional performance which are behind plan or forecasting to be behind – most significantly Gynaecology and the Hewitt Centre.

Maternity: Overall the divisional position remains ahead of plan YTD (£0.3m) and is forecast to be £0.4m underspent full-year (after the additional cost of planned midwife recruitment is factored in).

Gynaecology: The financial position in is now a cause for concern. Overall the in-month position is £0.2m adverse, reducing the YTD overall position to £0.1m favourable. The FOT is a £0.4m over-spend.

Neonatal: An overspend of £0.3m is expected in the full year, driven by recruitment (including an agreed additional consultant post above current establishment), and a prudent forecast on income.

Hewitt Fertility Centre: Given the continued reduced income seen over the past few months, the forecast has been amended downwards again and is now forecast to underperform by £0.5m, driven primarily by income under-achievement.

Theatres: There is a continued underspend on both pay and non-pay, even after the pay award impact, and both are £0.1m favourable to plan YTD, reflective of lower activity in both Gynaecology and Obstetrics.

Genetics: Services were again delivered within budget for Month 5 in month and YTD. The Trust is working with NHS England to ensure safe implementation of the laboratory reconfiguration, and no financial impact is expected from this in the current financial year. However there is future risk around this given uncertainties around the contract and service changes.

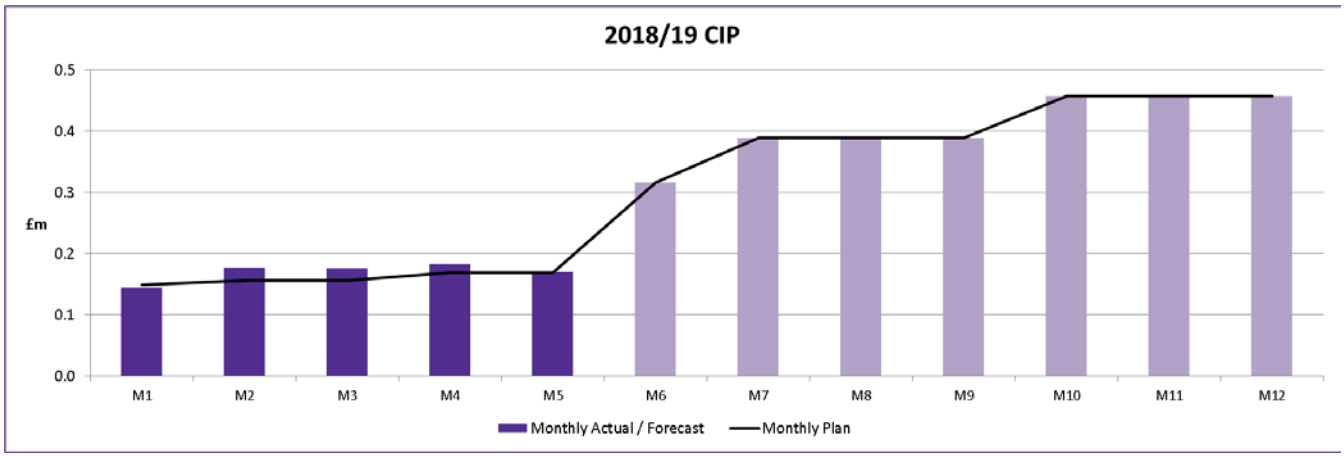
Clinical Support: This area was overspent in month and YTD, driven by agency usage. It is forecast to overspend due to continued overspends on agency, and the impact of the loss of the anticipated £1m of CNST Maternity Incentive.

Corporate Services and Technical Items: Overall these are within plan in-month, YTD and in the forecast, although note that the position is benefitted by the pay award income of £0.9m being held centrally at Month 5.

Agency: Expenditure against agency staff remains well within the limits set by NHSI, with £0.4m incurred to date against the £1.8m annual cap. The Trust forecasts that it will continue to operate within this limit in 2018/19.

3. CIP

At Month 5 the Trust has delivered £0.2m against the in-month target of £0.2m, and is forecasting full delivery of the £3.7m CIP, albeit with significant non-recurrent elements. The 2018/19 CIP has been profiled in line with planned delivery, which shows the target increasing throughout the year as follows.



The Trust was informed in late August 2018 by NHS Resolution that the Maternity Incentive Payment would not be awarded, which constituted £1m of the CIP programme. This was appealed by the Trust, but NHS Resolution communicated in early September that this appeal was unsuccessful. Therefore the Trust is expecting not to achieve any of this CIP. However it should be noted that the Trust continues to lobby to ensure there is a robust system in place going into 2019/20, that the Trust can access, in line with the aims of the incentive.

In addition, the forecast also now assumes that the Electronic Patient Record CIP (£0.2m) will not be achieved, along with some other originally planned schemes. It is anticipated that this will be mitigated by non-recurrent underspends and initiatives, but clearly leaves a gap for planning 2019/20. Through the Turnaround and Transformation Committee the Trust is putting in place workshops to identify 2019/20

CIP, and ascertain if any of these schemes can be brought forward into 2018/19. The Trust is also exploring further Project Management Resource to help drive some of the schemes forward, particularly in light of other operational pressures.

4. Contract Performance

Income YTD is £1.6m higher than would have been received under PbR. This is driven by both Gynaecology and Maternity, which accounted for 92% of the block contract under-performance at Month 5 as set out below. Proportionately, gynaecology has the most support from this arrangement.

		Month 5			YTD Block		
Directorate	CCG	Block	Actual	Variance	Block	Actual	Variance
Maternity	Liverpool	2,492	2,282	(210)	12,446	11,926	(520)
Maternity	Knowsley	355	357	2	1,781	1,724	(57)
Maternity	South Sefton	593	526	(67)	2,960	2,694	(266)
Maternity	Southport & Formby	49	52	3	243	245	2
Maternity Total		**3,489**	**3,217**	**(271)**	**17,429**	**16,589**	**(840)**
Gynaecology	Liverpool	981	832	(150)	5,082	4,724	(358)
Gynaecology	Knowsley	212	182	(30)	1,098	902	(196)
Gynaecology	South Sefton	260	240	(20)	1,348	1,260	(89)
Gynaecology	Southport & Formby	37	22	(15)	191	156	(35)
Gynaecology Total		**1,490**	**1,276**	**(214)**	**7,721**	**7,042**	**(679)**
Hewitt	Liverpool	136	133	(3)	663	643	(20)
Hewitt	Knowsley	38	18	(20)	186	143	(43)
Hewitt	South Sefton	35	47	12	169	170	1
Hewitt	Southport & Formby	23	29	6	111	101	(10)
Hewitt Total		**231**	**227**	**(5)**	**1,129**	**1,057**	**(72)**
Other	Liverpool	11	7	(3)	55	43	(12)
Other	Knowsley	3	1	(1)	14	8	(6)
Other	South Sefton	3	3	0	15	11	(4)
Other	Southport & Formby	0	0	(0)	2	1	(1)
Other Total		**17**	**12**	**(5)**	**86**	**63**	**(24)**
Total		**5,227**	**4,732**	**(496)**	**26,365**	**24,750**	**(1,615)**

Block contract under-performance represents a significant financial risk to the Trust from 2019/20, when the existing 'Acting as One' contract will come to an end. This is being addressed through Operational Planning and Rightsize.

5. Forecast Out-turn

Given the impact of the loss of the CNST incentive, further work has been undertaken to assess whether the Trust will be able to achieve its control total and forecast out-turn (FOT) deficit position. With current available information, it has been assessed as likely that the Trust will be able to achieve the FOT, but it should be noted there are risks to this. The main mitigations that will allow this to happen are:

- Under-spends on pay due to vacancies and difficulties in recruitment in some areas;
- Under-spends on non-pay related to activity being lower than anticipated;
- Savings from the Transformation team.

Whilst this is positive for the 2018/19 position, it is the ongoing underlying position which is more a matter of concern. The table below shows the main cost pressures and mitigations in the Month 5 FOT.

		Cost Pressures £000	Mitigations £000
CIP	Extension of Meditech (CIP)	**-200**	
	CNST Maternity Incentive (CIP)	**-1,030**	
Activity-Related	Cost per Case Income	**-576**	
	Activity-related pay under-spend		**625**
	Activity-related non-pay under-spend		**798**
	Additional Acting as One Income		**342**
	Insourcing costs (RTT)	**-251**	
Other	Clinical Case for Change Underspend		**322**
	Transformation Team underspend		**414**
	Other Net Risks	**-444**	
Total		**-2,501**	**2,501**

It can be seen above that the Trust has expected cost pressures of around £2.5m in the forecast, which are being managed by a similar level of mitigation.

Whilst this is a positive position to be in, it should be noted that the expected underlying position has deteriorated significantly from plan. This is due to some of the mitigations above being non-recurrent in nature, and also an anticipated £3.8m non-recurrent benefit through 'Acting as One'.

6. Cash and Borrowings

The cash balance at the end of Month 5 was £6.1m compared to a 2017/18 year end position of £6.0m and is ahead of plan, due to the improved I&E position and higher than anticipated creditors and accruals.

Total borrowings now stand at £11.6m, following repayment of £5.6m of Distress Financing in July 2018.

7. BAF Risk

No changes to the BAF scores are proposed at Month 5.

8. Conclusion & Recommendation

The Committee are asked to note the Month 5 financial position.

Appendix 1 – Board Pack

Board Finance Pack M5.xlsx

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M5

YEAR ENDING 31 MARCH 2019

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M5
YEAR ENDING 31 MARCH 2019

USE OF RESOURCES RISK RATING	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR Budget	YEAR FOT
CAPITAL SERVICING CAPACITY (CSC)				
(a) EBITDA + Interest Receivable	372	1,646	5,053	5,019
(b) PDC + Interest Payable + Loans Repaid	842	6,381	2,684	8,095
CSC Ratio = (a) / (b)	**0.44**	**0.26**	**1.88**	**0.62**
NHSI CSC SCORE	**4**	**4**	**2**	**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	(5,478)	(9,908)	(2,385)	(7,973)
(b) Expenditure	47,169	45,790	111,627	110,928
(c) Daily Expenditure	308	299	306	304
Liquidity Ratio = (a) / (c)	**(17.8)**	**(33.1)**	**(7.8)**	**(26.2)**
NHSI LIQUIDITY SCORE	**4**	**4**	**3**	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)				
I&E MARGIN				
Deficit (Adjusted for donations and asset disposals)	2,326	1,061	1,601	1,601
Total Income	(47,531)	(47,416)	(116,656)	(115,911)
I&E Margin	**-4.9%**	**-2.2%**	**-1.4%**	**-1.4%**
NHSI I&E MARGIN SCORE	**4**	**4**	**4**	**4**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)				
I&E MARGIN VARIANCE FROM PLAN				
I&E Margin (Actual)		-2.20%		-1.40%
I&E Margin (Plan)		-4.90%		-1.40%
I&E Variance Margin	**0.00%**	**2.70%**	**0.00%**	**0.00%**
NHSI I&E MARGIN VARIANCE SCORE	**1**	**1**	**1**	**1**
Ratio Score 1 = 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%				

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

AGENCY SPEND				
YTD Providers Cap	752	752	1,805	1,805
YTD Agency Expenditure	535	446	1,284	1,173
	-28.9%	**-40.7%**	**-28.9%**	**-35.0%**
NHSI AGENCY SPEND SCORE	**1**	**1**	**1**	**1**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%				
Overall Use of Resources Risk Rating	**3**	**3**	**3**	**3**

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M5
YEAR ENDING 31 MARCH 2019

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
Income									
Clinical Income	(8,641)	(8,784)	143	(43,639)	(42,995)	(643)	(106,086)	(104,062)	(2,024)
Non-Clinical Income	(809)	(1,176)	367	(3,893)	(4,420)	528	(10,570)	(11,849)	1,279
Total Income	**(9,451)**	**(9,960)**	**510**	**(47,531)**	**(47,416)**	**(116)**	**(116,656)**	**(115,911)**	**(745)**
Expenditure									
Pay Costs	5,794	5,637	157	29,027	27,815	1,212	69,491	67,996	1,495
Non-Pay Costs	2,340	2,330	10	11,768	11,600	167	27,868	27,804	64
CNST	1,275	1,275	(0)	6,374	6,374	(0)	14,268	15,129	(860)
Total Expenditure	**9,409**	**9,242**	**167**	**47,169**	**45,790**	**1,379**	**111,627**	**110,928**	**699**
EBITDA	**(42)**	**(719)**	**677**	**(362)**	**(1,626)**	**1,263**	**(5,029)**	**(4,983)**	**(46)**
Technical Items									
Depreciation	382	425	(43)	1,857	1,927	(70)	4,586	4,741	(155)
Interest Payable	28	20	8	127	117	10	356	289	67
Interest Receivable	(2)	(4)	2	(10)	(20)	10	(24)	(36)	12
PDC Dividend	143	119	24	715	664	51	1,716	1,594	122
Profit / Loss on Disposal	0	0	0	0	0	0	0	0	0
Total Technical Items	**551**	**560**	**(9)**	**2,689**	**2,687**	**2**	**6,634**	**6,588**	**46**
(Surplus) / Deficit	**509**	**(159)**	**668**	**2,327**	**1,062**	**1,265**	**1,605**	**1,605**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
EXPENDITURE: M5
YEAR ENDING 31 MARCH 2019

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	361	361	0	1,805	1,728	77	4,331	4,217	114
Medical	1,377	1,319	58	6,884	6,500	384	16,521	15,720	801
Nursing & Midwifery	2,484	2,393	91	12,472	12,045	427	29,768	29,410	358
Healthcare Assistants	390	413	(23)	1,958	1,928	30	4,690	4,809	(119)
Other Clinical	558	547	11	2,790	2,652	138	6,696	6,501	195
Admin Support	168	183	(15)	839	807	31	2,013	1,992	20
Corporate Services	349	323	26	1,745	1,710	35	4,187	4,173	14
Agency & Locum	107	100	8	535	445	90	1,285	1,173	112
Total Pay Costs	**5,794**	**5,637**	**157**	**29,027**	**27,815**	**1,212**	**69,491**	**67,996**	**1,495**
Non Pay Costs									
Clinical Suppplies	740	842	(102)	3,724	3,705	18	8,930	8,513	417
Non-Clinical Supplies	508	459	49	2,546	2,347	199	6,009	5,554	455
CNST	1,275	1,275	(0)	6,374	6,374	(0)	14,268	15,129	(860)
Premises & IT Costs	458	595	(137)	2,295	2,521	(226)	5,303	5,932	(628)
Service Contracts	634	433	200	3,203	3,027	177	7,626	7,806	(180)
Total Non-Pay Costs	**3,615**	**3,605**	**10**	**18,142**	**17,975**	**167**	**42,136**	**42,932**	**(796)**
Total Expenditure	**9,409**	**9,242**	**167**	**47,169**	**45,790**	**1,379**	**111,627**	**110,928**	**699**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M5
YEAR ENDING 31 MARCH 2019

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
Maternity									
Income	(3,989)	(4,004)	15	(19,924)	(19,763)	(161)	(47,997)	(47,532)	(465)
Expenditure	1,777	1,820	(43)	8,889	8,387	502	21,332	20,505	827
Total Maternity	**(2,212)**	**(2,184)**	**(28)**	**(11,035)**	**(11,376)**	**341**	**(26,665)**	**(27,027)**	**362**
Gynaecology									
Income	(2,089)	(1,967)	(122)	(10,788)	(10,843)	55	(26,139)	(26,179)	41
Expenditure	890	942	(52)	4,469	4,412	57	10,557	11,023	(466)
Total Gynaecology	**(1,198)**	**(1,025)**	**(174)**	**(6,319)**	**(6,431)**	**112**	**(15,582)**	**(15,156)**	**(426)**
Theatres									
Income	(39)	(39)	0	(195)	(196)	2	(467)	(472)	5
Expenditure	668	638	30	3,353	3,109	243	8,036	7,723	313
Total Theatres	**629**	**599**	**30**	**3,158**	**2,913**	**245**	**7,569**	**7,251**	**317**
Neonatal									
Income	(1,369)	(1,406)	37	(6,842)	(6,890)	48	(16,388)	(16,324)	(64)
Expenditure	1,012	1,155	(144)	5,062	5,004	59	12,148	12,351	(203)
Total Neonatal	**(357)**	**(251)**	**(107)**	**(1,779)**	**(1,886)**	**107**	**(4,240)**	**(3,972)**	**(267)**
Hewitt Centre									
Income	(857)	(810)	(47)	(4,324)	(3,977)	(348)	(10,555)	(10,007)	(548)
Expenditure	629	654	(26)	3,149	3,138	11	7,556	7,514	42
Total Hewitt Centre	**(228)**	**(155)**	**(73)**	**(1,175)**	**(838)**	**(337)**	**(2,999)**	**(2,493)**	**(506)**
Genetics									
Income	(603)	(613)	10	(3,018)	(3,092)	74	(7,246)	(7,291)	46
Expenditure	468	458	10	2,342	2,300	42	5,620	5,499	121
Total Genetics	**(135)**	**(155)**	**20**	**(676)**	**(793)**	**116**	**(1,625)**	**(1,792)**	**167**
Clinical Support									
Income	(27)	(24)	(3)	(133)	(120)	(14)	(330)	(310)	(21)
Expenditure	759	804	(45)	3,795	3,863	(68)	8,912	9,289	(377)
Total Clinical Support & CNST	**731**	**779**	**(48)**	**3,661**	**3,743**	**(82)**	**8,581**	**8,979**	**(398)**
Corporate & Trust Technical Items									
Income	(477)	(1,097)	620	(2,307)	(2,535)	228	(7,534)	(7,797)	263
Expenditure	3,757	3,329	427	18,800	18,264	535	44,100	43,611	489
Total Corporate	**3,280**	**2,232**	**1,047**	**16,493**	**15,730**	**763**	**36,566**	**35,815**	**751**
(Surplus) / Deficit	**509**	**(159)**	**668**	**2,327**	**1,062**	**1,265**	**1,605**	**1,605**	**(0)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
CIP: M5
YEAR ENDING 31 MARCH 2019

SCHEME	MONTH 5			YTD			YEAR		
	TARGET	ACTUAL	VARIANCE	TARGET	ACTUAL	VARIANCE	TARGET	FOT	VARIANCE
Legal Premium Reduction	0	0	0	0	0	0	1,030	0	(1,030)
Patient Flow & Demand	0	0	0	0	0	0	95	65	(30)
Service Development Income	11	4	(7)	47	22	(24)	124	70	(53)
Service Development Non Pay	32	31	(1)	157	155	(3)	482	379	(103)
Service Development Pay	9	4	(5)	30	21	(9)	240	50	(191)
System & Environmental Income	7	6	(1)	27	26	(1)	73	68	(5)
System & Environmental Non Pay	6	25	20	19	38	19	147	152	5
Technology	26	26	0	130	123	(6)	515	309	(206)
Workforce	80	62	(18)	392	304	(88)	949	747	(202)
Non-recurrent Mitigation	0	12	12	0	161	161	0	1,816	1,816
TOTAL	**170**	**170**	**1**	**801**	**850**	**48**	**3,656**	**3,656**	**0**

*Scheme names as per NHSI return

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M5
YEAR ENDING 31 MARCH 2019

BALANCE SHEET £'000	YEAR TO DATE Opening	M05 Actual	Movement
Non Current Assets	**76,313**	**78,141**	1,828
Current Assets			
Cash	6,013	6,190	177
Debtors	8,407	6,748	(1,659)
Inventories	452	490	38
Total Current Assets	**14,872**	**13,428**	**(1,444)**
Liabilities			
Creditors due < 1 year	(11,257)	(17,925)	(6,668)
Creditors due > 1 year	(1,686)	(1,673)	13
Loans	(17,221)	(11,621)	5,600
Provisions	(4,514)	(4,905)	(391)
Total Liabilities	**(34,678)**	**(36,124)**	(1,446)
TOTAL ASSETS EMPLOYED	**56,507**	**55,445**	**(1,062)**
Taxpayers Equity			
PDC	38,451	38,451	0
Revaluation Reserve	15,367	15,367	0
Retained Earnings	2,689	1,627	(1,062)
TOTAL TAXPAYERS EQUITY	**56,507**	**55,445**	**(1,062)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT AND BORROWINGS: M5
YEAR ENDING 31 MARCH 2019

CASHFLOW STATEMENT	YEAR TO DATE		
£'000	Budget	Actual	Variance
Cash flows from operating activities	(1,494)	(301)	(1,193)
Depreciation and amortisation	1,857	1,926	(69)
Movement in working capital	(1,765)	8,016	(9,781)
Net cash generated from / (used in) operations	**(1,402)**	**9,641**	**(11,043)**
Interest received	10	20	(10)
Purchase of property, plant and equipment and intangible assets	(5,643)	(3,819)	(1,824)
Proceeds from sales of property, plant and equipment and intangible assets	0	0	0
Net cash generated from/(used in) investing activities	**(5,633)**	**(3,799)**	**(1,834)**
PDC Capital Programme Funding - received	0	0	0
Loans from Department of Health Capital - received	1,566	0	1,566
Loans from Department of Health Revenue - received	483	0	483
Loans from Department of Health Revenue - repaid	0	(5,600)	5,600
Interest paid	(27)	(65)	38
PDC dividend (paid)/refunded	0	0	0
Net cash generated from/(used in) financing activities	**2,022**	**(5,665)**	**7,687**
Increase/(decrease) in cash and cash equivalents	**(5,013)**	**177**	**(5,190)**
Cash and cash equivalents at start of period	6,013	6,013	0
Cash and cash equivalents at end of period	**1,000**	**6,190**	**(5,190)**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding at M05
Loans from Department of Health Capital (ITFF)- 2.0% Interest Rate	5,500	(1,529)	3,971
Loans from Department of Health Capital (Neonatal)- 2.54% Interest Rate	1,000	0	1,000
Loans from Department of Health Revenue - 1.50%	14,612	(7,962)	6,650
Total	**21,112**	**(9,491)**	**11,621**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CAPITAL EXPENDITURE: M5
YEAR ENDING 31 MARCH 2019

CAPITAL EXPENDITURE

£'000	Full Year Budget	Year to Date Actual	Residual Capital Budget
Neonatal New Building	6,968	517	6,451
Other Building Projetcs	293	12	281
Estates & Environmental Projects	441	36	405
Global Digital Examplar Fast Follower Technology	2,800	2,467	333
Information Management & Technology (IM&T) Projects	400	249	151
Medical Equipment	1,418	493	925
Other	222	0	222
Total	**12,542**	**3,774**	**8,768**

Note: The Capital Expenditure is shown on an "Accruals" basis based on the date of receipt of the capital item by the Trust. This figure differs to the capital expenditure figure shown in the cashflow statement which is on a "Cash" basis.

Agenda Item	2018/266

MEETING	**Board of Directors**	
PAPER/REPORT TITLE:	**Board Assurance Framework**	
DATE OF MEETING:	Friday, 05 October 2018	
ACTION REQUIRED	**For Assurance**	
EXECUTIVE DIRECTOR:	Colin Reid, Trust Secretary	
AUTHOR(S):	Christopher Lube, Head of Governance	
STRATEGIC OBJECTIVES:	***Which Objective(s)?***	
	1. To develop a well led, capable, motivated and entrepreneurial *workforce*	☐
	2. To be ambitious and *efficient* and make the best use of available resource	☐
	3. To deliver *safe* services	☒
	4. To participate in high quality research and to deliver the most *effective* Outcomes	☐
	5. To deliver the best possible *experience* for patients and staff	☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***	
	1. *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust*	☐
	2. *The Trust is not financially sustainable beyond the current financial year*	☐
	3. *Failure to deliver the annual financial plan*	☐
	4. *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision*	☐
	5. *Ineffective understanding and learning following significant events*	☒
	6. *Inability to achieve and maintain regulatory compliance, performance and assurance*	☒
	7. *Inability to deliver the best clinical outcomes for patients*	☒
	8. *Poorly delivered positive experience for those engaging with our services*	☒
CQC DOMAIN	***Which Domain?***	
	SAFE- *People are protected from abuse and harm*	☐
	EFFECTIVE - *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.*	☐
	CARING - *the service(s) involves and treats people with compassion, kindness, dignity and respect.*	☐
	RESPONSIVE – *the services meet people's needs.*	☐
	WELL-LED - *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.*	☐
	ALL DOMAINS	☒

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: 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:*** 1. Agree any changes referenced in the dashboard at appendix 1 2. Note the assurance presented re process and proposal(s) within this report. 3. Advise the Governance team of approval /views in respect of the process, proposals and rationale.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Sub Committees of the Board
	Date of meeting	During September 2018

Executive Summary

The Board Assurance Framework (BAF) is one of the tools that the Trust uses to track progress against the organisations Strategic Aims. As part of the development of the BAF, each financial year, the Key priorities of the year are identified and the potential risks to achieving these assessed for inclusion on the framework. As such, all risk on the BAF are set out under strategic aims.

The BAF is based on based on seven key elements:

- Clearly defined Key Priorities for 2018/19 (aligned to the Trust Strategic Aims)
- Clearly defined principle risks to the key priorities together with an assessment of their potential impact and likelihood.
- Key controls by which these risk can be managed.
- Potential and positive assurance that risk are being reasonably managed.
- Board reports detailing how risk are being managed and objectives met, together with the identification of gaps in assurances and gaps in control.
- Risk reduction plans, for each risk, which ensures the delivery of the objectives, control of risk and improvements in assurances.
- A target risk rating.

The Head of Governance and Quality continues to meet with each of the Executive Director leads on a monthly basis to ensure the BAF is maintained as a live document.

Each of the sub committees of the Trust Board with BAF risks continues to have the responsibility to review and gain assurance to controls and any required actions.

Report

1. Introduction

This report seeks to assure and inform the Board of the process and outcomes from Board and sub-committee review of risks assigned to the Board Assurance Framework.

Any changes in risk score or escalation / de-escalation proposals made by sub-committees after consideration of risks within their remit are conveyed via the Head of Governance and Quality to ensure reflection of proposed and approved changes in the BAF dashboards.

The current BAF is embedded below:

BAF Risks – September 2018: see appendix 1

2. Sub-Committee Changes to Risks

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

There have been some changes to risk descriptions to gain greater clarity and additions to controls since the last report to the Board. Other changes to the BAF risks currently on the register and these mainly relate to identifying completed actions and new revised dates added to planned actions.

3. New Risks and Closed Risk

Since the last report to the Trust Board there have been no new risks added to the BAF and no risks have been closed.

4. Conclusions / Recommendations

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

The Board are asked to:

1. Agree any changes referenced in the dashboard at appendix 1
2. Note the assurance presented re process and proposal(s) within this report.
3. Advise the Governance team of approval /views in respect of the process, proposals and rationale.

2018/19 Live Board Assurance Framework – September 2018

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, lack of leadership ~~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 • Two 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** • National Staff surrey (annual) • Quarterly internal staff survey (Go Engage System) • Monthly KPI's for controls • Performance Reports (monthly) • Quarterly Learning Events • Bi-annual Speak up Guardian Reports • Report form Guardian of Safe Working **Metrics** • Increase in managers attending training programme • Mandatory training data • Absence data • Turnover data • Whistleblowing data • Staff Engagement Score • Sickness data • Guardian for Safe Working Exception Reports	**Assurance Gaps** ~~• CQC Whistleblowing~~ • None at this time	• PPF deep dive into service workforce risks ~~• Develop programme of Development Centres~~ • Aspirant Managers programme being rolled out • Executive Team and staff side walkabouts • Launch of Fair and Just Culture Project • Revised People Strategy • Roll out of engagement tool	• Monthly monitoring ~~• Q2 2018/19~~ • Monthly monitoring 2018 • Monthly monitoring 2018 • July 18 • Nov 18 • December 2018
Risks from Risk Register • 8 x Service Risks			**Independent / semi-independent** • POPPY study • RCM culture survey findings due Q1/2 2018 • CQC regulatory inspection in 2018 • National Workforce and Wellbeing Charter -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**	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

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 – 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. 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 quarterly for concerns to be raised. • Remediation Policy. • Monitoring exercises undertaken on annual basis to	• 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 validates Jr Dr work plans • 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.~~ • Annual GMC Survey • Strategic Workforce reporting to PPF **Metrics** • Exception reporting data • Monitoring exercise data • Absence data from Lead Employer • Whistleblowing reports	**Assurance Outcomes** • 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 reporting to Education Governance & PPF – no areas of specific concern identified **Assurance Gaps** • None 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 for Gynaecology • Operational Plan for increased number of consultants • GMC Survey 2018 action plan to be agreed • ~~Development and implementation of New DME Education Strategy~~	• ~~Monthly monitoring~~ • Monthly monitoring • Monthly monitoring • Monthly Monitoring • Sept 2018 • Sept 2018

	Risks from Risk Register • 2 x Corporate Risks • 9 x Service Risks	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 • ~~Medical Workforce Group chaired by MD~~ • Strategic Workforce Group established • Advanced and Enhanced nursing and midwifery roles		**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: Eva Horgan

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 (inc delivery of EPR) • 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	• December 18 (revised date) • March 19 (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: Eva Horgan

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 (inc EPR delivery and CNST contribution reduction) • 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 • Vacancy control process well established and monitored	• Lose of CNST maternity incentive monies	**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 31.3.18		
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

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

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 March 2018 • Fire risk assessments completed and plan for improvement works in place and being actioned	• Clinical case for change is dependent on decision making external to the trust (CCG, NHSI, NHSE) • Financial constraints for delivery of facilities improvements	**Management assurance** •Corporate Objectives 2018-19 •Board Performance Reports •DIPC Reports •Staffing Reports to Board •Incident and SI reports to Safety Senate and Board **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 (2018) • 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	• Agree a business case for a new build • Submission of capital bid • Commence public consultation	• Monthly monitoring (external lead) • April 2019 (revised date) • Monthly monitoring (NHSE lead)
Risks from Risk Register • 12 x Corporate Risks						

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:** Christopher Lube | **Assurance Committee:** Quality Committee (QC)

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 3 yr programme in progress • 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 • 1st year of Quality Strategy Delivered	• 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.	**Management assurance** • CQPG Meetings • Reporting of incidents and management of action plans through Safety Senate • Reflection of risks and Cooperate Risk Register and Board Assurance Framework • CQC Assessment • Annual Quality Account Report **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 assessment form 2018 visit Safe as 'Good' across all areas of the Trust • NRLS Incident Reporting Report • MIAA report on Duty of Candour • Safety Senate Reports	**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 **Outcomes** • CQC assessment form 2018 visit Safe as 'Good' across all areas of the Trust	• 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 • Fair and Just culture Project • Maintain close involvement with regional and local safety collaborative	• October 18 (revised date) • October 18 (revised date) • October 18 (revised date) • Oct 18 • Dec 2018 • Monthly monitoring (revised date)
Risks from Risk Register • 3 x Corporate Risks • 11 x Service Risks						

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: Caron Lappin | **Operational Lead:** Christopher Lube | **Assurance Committee:** Quality Committee (QC)

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 • Completion and Submission of Annual Quality Report	• 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 • 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.	• October -18 (revised date) • 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) Good' for the Trust	**Outcomes** • Collaborative meetings with CCG • CQC assessment form 2018 visit as 'Good' for the Trust		

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) Failure to Deliver at agreed schedule of October 2018 Implementation of a system that is not fit for purpose **Cause:** Poor program management and product design **Consequence:** Impact on Patient Safety Quality and Experience Impact on patient and clinical services, such as e-prescribing, staff documentation and consent. Unable to meet contractual reporting arrangements linked to performance and finance Financial impact on delivery of control total leading to inability to deliver annual plan 2018/19 and beyond	• 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 and engagement plan in place	• Concern as to supplier management and product functionality • Programme board ineffective and requires top down focus • 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 • Key partner awaiting NHSI approval and has not agreed contract with supplier	**Management assurance** • Executive Sign off programme plan • Clinical (operational) sign off • Bi-weekly Exec Team Briefing from CIO • Oversight from Digital Hospital Sub-group • Regular reporting to FPBD • Inclusion of LWH NED on EPR Program Board • Appointment of external Program Director in Jan 18 • MIAA gateway reviews **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** • Ability to influence supplier Functionality of modules for Maternity, Theatres and e-prescribing • Appetite of other Trusts to prioritise the program • Effectiveness of Program Board **Outcomes** • Full EPR against planned date • No impact on the delivery of control total in 18/19 • Supports the delivery of £3.6m CIP for 18/19	• Test System built and tested against clinically approved script • Recommendations undertaken of audit and repeat audit by MIAA • Delivery of live system against design and configuration set-out through the programme and clinically signed off. • Completion of the business intelligence strategy to enable the successful delivery of statuary and operational reporting post deployment	• Completed for Wave One elements, to complete for Wave 2 (requires the completion of the detailed ISC plan) TBC • Recommendations completed, follow up Audit to be scheduled for August 2018 • Under review following rebasing of plan. Timescales to be determined following EPR Program Board in July 2018 • Strategy approved by programme board in March 2018 in readiness for deployment against plan.
Risks from Risk Register • 2024 – IM&T service risk						

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**	5	5	**25**	5	5	**25**

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: Caron Lappin | **Operational Lead:** Devender Roberts | **Assurance Committee:** Quality Committee (QC)

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 2018 • 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) • Consultant Nurse job plans	**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.	• Continue to explore potential for direct research relationships with other local trusts and universities	• Ongoing process to be reviewed in October 2018 (revised date)
Risks from Risk Register • 4 x 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** • CQC rating Good 2018 • 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**

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: Caron Lappin

Operational Lead: Michelle Morgan

Assurance Committee: Quality Committee (QC)

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** • 2 x 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 • All staff , Trust members and volunteers have exit surveys	• 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 for MW • Insufficient quality of interpretation services • Nurses and AHP's supervision needs development and implementation • Access centre and bookings • Telephone line services for booking and advice in GED and MAU	**Management assurance** • Patient stories (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 • Board Walkabouts (1/12) **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. • Respond to the findings of the CQC's national surveys (Maternity / Inpatient)	• November-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**