Meeting of the Board of Directors
HELD IN PUBLIC
Friday 1 February 2019 at 0930hrs
Liverpool Women's Hospital
Board Room

Item no. 2019/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
	Thank you	To provide personal and Team thank you – above and beyond			0930 (10mins)	caring
001	Apologies for absence Declarations of interest	Receive apologies	Verbal	Chair		-
002	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		Well Led
003	Patient Story	To receive a patients story	Presentation	Patient's parent	0940 (20mins)	Safe, Experience, Well led
004	Minutes of the previous meeting held on 7 December 2018	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1000 (5mins)	Well Led
005	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair		Well Led
006	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1005 (10mins)	Well Led
007	Chief Executive Report	Report key developments and announce items of significance not elsewhere	Written	Chief Executive		Well Led

Item no. 2019/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
BOARD COMMITTEE ASSURANCE						
008	Chair's Report from Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1015 (20mins)	Well Led
009	Chair's Report from Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair		Well Led
010	Chair's Report from Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair		Safe Well Led
011	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						
012	1. Safeguarding Annual Report 2017/18 2. Care Quality Commission (CQC) Review of Health Services for Looked After Children and Safeguarding in Sefton – implications for Liverpool Women's	To approve To Note the position and advise on any actions from the discussion	Written Written	Associate Director of Nursing and Midwifery for Safeguarding	1035 (10mins)	Safe Well Led
013	Listening Events Summary Report – 12month review	For information and assurance	Written	Director of Workforce and Marketing	1045 (10mins)	Well Led, caring
014	Putting People First Strategy 2019-2024	For approval	Written	Director of Workforce and Marketing	1055 (05mins)	Well Led, caring
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES						
015	1. Bi-Annual Safe Staffing Review 2. Safer Nurse/Midwife Staffing Monthly Report period 8&9 2018/19	For assurance and to note any escalated risks	Written	Director of Nursing and Midwifery	1100 (10mins)	Well Led, caring, Safe

Item no. 2019/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
016	Operational Performance Report period 9, 2018/19	For assurance –To note the latest performance measures	Written	Director of Operations	1110 (10mins)	Well Led
017	Finance Report period 9, 2018/19	For assurance - To note the current status of the Trusts financial position	Written	Director of Finance	1120 (10mins)	Well Led
TRUST STRATEGY						
018	Future Generations	For noting.	Verbal	Chief Executive	1130 (5mins)	Well Led
BOARD GOVERNANCE						
019	Board Assurance Framework	For assurance and approval	Written	Trust Secretary	1135 (05mins)	Well Led
020	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1140 (05mins)	Well Led
HOUSEKEEPING						
021	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1145 Meeting ends	Well Led

Date, time and place of next meeting Friday 4 April 2019

Meeting to end at 1145

1145-1155	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 December 2018 at 0900 hrs
at Liverpool Women's NHS Foundation Trust, Crown Street Liverpool.

PRESENT

Mr Robert Clarke	Chair
Ms Jo Moore	Non-Executive Director & Vice Chair
Mr Phil Huggon	Non-Executive Director
Mrs Michelle Turner	Director of Workforce & Marketing
Dr Andrew Loughney	Medical Director & Deputy Chief Executive
Mrs Caron Lappin	Director of Nursing and Midwifery
Mrs Jenny Hannon	Director of Finance
Mr Jeff Johnston	Director of Operations
Mr Ian Knight	Non-Executive Director
Dr Susan Milner	Non-Executive Director

IN ATTENDANCE

Mr Colin Reid	Trust Secretary
Mrs Gillian Walker	Deputy Matron, Gynaecology (item 278-280)
Mrs Melanie Pickering	Head of Nursing, Gynaecology
Dr Devender Roberts	Deputy Medical Director (item 290)

APOLOGIES:

Mrs Kathryn Thomson	Chief Executive
Mr Tony Okotie	Non-Executive Director/SID

2018

Thank You

Val Irving, Neonatal – The Director of Nursing and Midwifery provided the thank you on behalf of the Board. The Director of Nursing and Midwifery advised the Board that Val had recently presented to Putting People First Committee in October relating to workforce performance on the neonatal unit. The Director of Nursing and Midwifery explained that it was very clear as she talked and engaged the Committee that Val had fantastic leadership skills that she was able to deliver on the unit but was also adapt to the changing needs of the service. Val clearly knows and understood them her staff and what made the presentation stand out was the flexibility and nurturing of the staff that Val brought to the Unit to create a solid workforce that was sustainable to deliver the service. The Director of Nursing and Midwifery advised that she had only worked with Val for 4 months but has been very impressed with what she has seen so far; someone who is clearly passionate about her service but also the wellbeing of her staff and patients. The Director of Nursing and Midwifery advised that she knows that Val has been thinking of retiring for some time and as a result was actively growing her staff as part of succession planning. Whoever takes on Val role in the future would have big shoes to fill.

Chris Webster, Macmillan CNS and Lead cancer nurse – The Director of Nursing and Midwifery provided the thank you on behalf of the Board. The Director of Nursing and Midwifery advised the

Board that Chris would be retiring this month and reported that she had been employed by the Trust for 20 years as a Macmillan nurse and Lead Cancer Nurse. The Director of Nursing and Midwifery ran through Chris's career at the Trust highlighting the key points in her career and the numerous awards she had received at local and national level. Chris has had the recognition of her peers, locally, regionally and nationally both for gynaecology and specialist palliative care and there is a recognition that patients were at the heart of everything she does and she is clinically driven in her development of the team and service; a testament to Chris is that patients keep in touch with her many years after discharge. Chris is a go to person with a wealth of knowledge and her unassuming nature, professionalism and kindness means she makes time for everyone. Chris has truly made a difference and will leave a legacy in this hospital and also regionally. The Director of Nursing and Midwifery on behalf of the Board acknowledged the work Chris had done and say a massive thank you from everyone in the Trust.

Jon Topping, Associate Medical Director and Consultant Obstetrician – The Medical Director gave the thank you on behalf of the Board. He advised the Board on Jo's work at the Trust started her training in 1984 and became a Consultant Obstetrician with an interest in early pregnancy at Liverpool Women's Hospital in 2000. During her 18 years at Liverpool Women's she has been, college tutor, Clinical Director for Maternity and Acting Medical Director and more recently, Associate Medical Director for Appraisal and Revalidation. The Medical Director recognised Jo's work over the time at Liverpool Women's and her involvement with external organisations such as the GMC. He personally thanked Jo for her support over the last few years since he joined the Trust and Jo's work as acting Medical Director at a time when the Trust was developing its Future Generations strategy and her commitment to the Trust and the Strategy.

278 **Apologies** – as above.
Declaration of Interests – None
Welcome: The Chair opened the meeting.

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

280 **Patient Story Presentation**
The Director of Nursing and Midwifery introduced the patient Story explaining that the story had resonance to the recommendation of the CQC following their inspection in February 2018 relating to patient dignity. Gill Walker, Deputy Matron, Gynaecology provided the presentation on a patient who was an ambulatory admission. Gill Walker explained that the patient had previously been a patient at the Trust in 2016 and was due to have a hysteroscopy procedure in November 2018. The patient had been anxious about coming back to the Trust for the second procedure due to privacy and dignity concerns arising from her first procedure in 2016.

Gill Walker provided details of the patients 2016 experience, explaining that on admittance: the room she was admitted into was dark and felt like a large cupboard that had found to put people in; the patient felt very uncomfortable when taken into a curtained off area and asked medical questions which she felt she could not respond to adequately because she was aware the rest of the room could hear her; the patient was able to overhear many other conversations including consultations, especially from older people who had hearing problems and were raising their voices; the patient felt guilty for feeling selfish – she had her own problems and did not want to hear everyone else's; the patient was asked to get changed into a gown and then discovered her procedure would not be going ahead for another 2 hours – this had not been communicate to her previously; the patient felt claustrophobic, although she had never had this feeling before and felt she could not just sit in this area in a gown waiting, consequently the patient put her clothes back on and returned 30 minutes before the procedure.

Gill Walker advised on the actions taken to address the room and in particular reported that a changing room had been turned into a private consultation room. Additional alterations were made to the waiting room to make the room less oppressive and accessible. Gill walker advised that the patients experience in November 2018 was much better. The patient felt the atmosphere was completely different and less oppressive. When consultation took place she was called into a separate private consulting room (previously the changing room) so that an open conversation could take place and she was only asked to get changed near to the procedure time and not hours before. Gill walker advised that the patient had said that on both occasions the care from the staff was excellent and that she was pleased to see a vast improvement in the unit in response to patient feedback.

The Board discussed the need to improve the feedback from the Friends and Family test and noted the work taking place by the Patient Experience Team and Volunteers to support front line staff in obtaining the feedback. Phil Huggan questioned whether there were any other sub-zero rooms being used by patients and it was reported that an assessment would take place to identify whether any existed.

The Chair thanked Gill Walker for the presentation and asked that his thanks and that of the Board were passed onto the patient.

281 Minutes of previous meeting held on Friday 5 October 2018

The minutes of the board meetings held on 5 October 2018 were approved.

282 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. The Board noted that, with regards to minute 261 - Neonatal Build GMP Approval, the Director of Finance and the Director of Operations had approved that the additional checks had been undertaken to their satisfaction.

283 Chair's Announcements

The Chair reported on the following matters:

Service of Remembrance held on Wednesday 10th October 2018 at St Georges Hall: The Chair thanked all members of staff involved in the organisation of the event.

Governor Meetings: The Chair reported on the activity of the Council at their Group Meetings and Council meeting in October 2018 and the Annual Members Meeting on 13 October 2018.

Board to Board: The Chair reported on the Board to Board meeting the Trust Board had with Alder Hey Children's Hospital. He felt that as a matter of principle it was good to have such an event however felt that the agenda items could have been more structured towards future workings particularly around the single neonatal service. He also felt that the attendees should have been restricted to Board members; noting that there was a large number of non-Board members attending from Alder Hey. The Board noted that future Board to Boards with other providers in the city would be advantageous, particularly with The Royal.

Chair Visibility - Innovation Park and Aintree: The Chair reported on his visit to the IM&T team at the Innovation Centre and the Aintree Centre for Women's Health. He found both visits beneficial. The Chair asked that the Board use the facilities of the Innovation Centre for a future meeting or workshop.

Listening Event: The Chair noted that a report would be presented to the meeting on 1 February 2019 regarding the output of the listening event held on 28 November 2018.

The Board noted the Chair's verbal update.

The Board agreed to take the Mortality Report Q2 2018/19 out of sequence.

290 Mortality Report Q2, 2018/19

Devender Roberts, Deputy Medical Director presented the Mortality Report for Q2, 2018/19 and explained that the report provides an update on the Trust systems and processes to review and learn from deaths of patients under their care. The Deputy Medical Director advised that the report was set out in accordance with recommendations by the National Quality Board and the Care Quality Commission and outlines the work taking place operationally and overseen by Effectiveness Senate and Quality Committee.

The Deputy Medical Director advised that there had been one out of hospital death in August 2018. A multidisciplinary panel was set up and following discussion on the care provided the MDT was agreed that all decision making was appropriate. There were a number of lessons to be learnt from the death which was agreed at the review; however the panel felt that any implementation of the lessons learned would not have changed the outcome for the patient. The Deputy Medical Director advised that the incident did not meet the criteria for a reportable SI; however the death would be revisited once information from a review to be carried out by The Royal Liverpool and Broadgreen University Hospitals NHS Trust and the findings of the post mortem becomes available. The Deputy Medical Director advised on the learning outcomes from the death that included: escalation and communication issues; observations, an audit of observations charges for regularity of observations post operatively; and the consistency of administering Fragmin, review SOP for peri-operative Fragmin.

Responding to a question on benchmarking the Trust's performance discussed at previous meetings, the Deputy Medical Director advised that this was still work in progress and reported on the difficulty of finding data that the Trust could be benchmarked against. She advised that in order to get any meaningful data the Trust would have to review all deaths due to the very small number that had occurred. The Deputy Medical Director advised that she would continue to look at developing learning and benchmarking via other specialist trusts.

The Chair thanked the Deputy Medical Director for her report. The Board received assurance that there as adequate progress made against the requirements laid out by the National Quality Board and noted that there were effective governance processes in place to improve quality and learning from the deaths of patients in receipt of care at the Trust.

284 Chief Executive's report

The Medical Director & Deputy Chief Executive referred to the Chief Executive's report and commented on the following:

Divisional Structure: The Medical Director & Deputy Chief Executive referred to the section on the new divisional structure and reported that the structure was still in its infancy and would be fully implemented by the beginning of the new financial year.

Genetics: The Medical Director & Deputy Chief Executive update the Board on the current status of the Northwest Genomics Strategic Partnership.

North West Genomics Laboratory Hub: The Medical Director & Deputy Chief Executive reported on the appointment of Lynn Greenhalgh to the role of Medical Director of the North West Genomics Laboratory Hub from 28th January 2019. This was a part time role, two days a week based at the Genomics Laboratory at St Mary's Hospital Manchester. The Board congratulated Lynn on her

appointment.

NHS Providers North of England Medical Directors Meeting: The Medical Director & Deputy Chief Executive reported on his attendance at the NW Medical Directors' Forum.

Carter at Scale: Referring to the section on Carter at scale the Medical Director and Deputy Chief Executive reported that discussions were ongoing regarding developing greater collaboration with respect to procurement and payroll. He noted that with regards to both of these areas the Trust was already collaborating in provision of the services.

The Chair thanked the Medical Director & Deputy Chief Executive for presenting the Chief Executive Report, which was noted.

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

The Chair asked Jo Moore to present the Chairs report from the FPBD meeting held on 22 October 2018 and 26 November 2018.

Referring to the most recent Committee meeting Jo Moore advised on the assurance the Committee had received regarding the delivery of the 2018/19 financial control total and recognised that this had been achieved due to positive position arising from the acting as one contract with Liverpool CCG and the delivery of CIP. Referring to delivery of CIP, Jo Moore advised that this was achieved through non recurrent savings and that the Committee was focused on delivery of recurrent CIP in 2019/20.

Jo Moore referenced the discussion on delivery of the Trust's RTT and Cancer targets and noted that these would be discussed later in the meeting together with the Finance Report and the 6 monthly reviews of the Operational Plan and Corporate Objectives. Referring to the timing of the decision for the capital funding for the proposed new build, Jo Moore advised that the date had been put back to December 2018 with no specific day identified.

Jo Moore advised on the additional assurances the Committee had received on the Trust's delivery of the EPRR Core Assurance Framework and advised that a paper providing that assurance would be presented later in the meeting. Jo Moore advised that the Committee were assured that the Trust remained focused on continuing to meet its duties under the Civil Contingencies Act and to achieve a rating of 'full compliance' against the EPRR Core Standards for 2019/20.

Jo Moore advised that the BAF had been reviewed and in light of the assurance it had received regarding the delivery of the 2018/19 control total, the Committee recommends to the Board that the current risk score for the "delivery of the annual plan 2018/19" risk should be reduced to 20 (from 25) by reducing the likelihood of the risk from 5 to 4. The Chair noted that approval would be sought under the Board Assurance Framework agenda item.

The Chair's Report from Finance, Performance and Business Development Committee was noted.

286 Chair's Report from Quality Committee (QC)

Phil Huggan agreed to present the Chair Report from the Quality Committee meetings held on 23 October 2018 and 26 November 2018 and advised that the Committee had received assurance from each of its sub-committees/senates on the work they had been carrying out.

With regards to Monthly Quality Performance Review he advised that like FBDB, the Committee had received an update on the Trust's performance for RTT and Cancer targets and in particular it was noted that the Trust was unlikely to be able to deliver all the cancer targets by the year end due to both internal clinical capacity and the provision of external supporting services; he noted this would be a matter for discussion later in the meeting.

Phil Huggan referred to the formulation of Patient Safety Walk rounds which were being developed to provide a consistent approach across the Trust. He explained that this would be developed in conjunction with Ward Accreditation that the Trust was currently seeking to achieve.

Referring to the Corporate Objectives 6 monthly review, Phil Huggan advised that as with FPBD the Committee had reviewed its allocated objectives and had agreed with the findings contained in the Report to be discussed later in the meeting. Phil Huggon advised that the Committee had also noted the future changes to the divisional structures within the Trust and felt that the Board should be exposed to the management teams over the next financial year. It was agreed that the Board workshops would be best placed to accommodate this request and asked the Trust Secretary with the Director of Operations would schedule such meetings into the work plan once the structure had bedded in.

The Chair thanked Phil Huggon for the report which was noted.

287 Chair's Report from Putting People First Committee (PPF)

The Chair noted Tony Okotie's apologies and the Director of Workforce and Marketing agreed to present the Chairs report from the PPF meeting held on 30 November 2018.

The Director of Workforce and Marketing ran through the work of the Committee highlighting the key assurances the Committee received. Referring to Brexit, the Director of Workforce and Marketing reported on the review of workforce undertaken by the Trust and reported that there was currently limited reliance on overseas workers from the EU and therefore the risks falling out of Brexit was minimal in relation.

Referring to the Putting People First Strategy 2019-2024, the Director of Workforce and Marketing reported that the final draft was presented to the Committee for approval at the meeting and would be presented to Board on 1 February 2019 for approval and implementation.

The Director of Workforce and Marketing drew the Board attention to the section on Workforce KPIs and in particular the concerns being addressed between the OLM and ESR recording of mandatory training and PDRs. She advised that the Committee was seeking assurance that both systems were accurately recording performance. The Director of Workforce and Marketing advised that both PDRs and mandatory training had consistently underperformed over the last 12 months and reported that actions plans were in place to recover the position.

Ian Knight asked whether Brexit was having or would have an impact on the Trust's access to drugs, the Director of Finance advised that there was currently there wasn't anything that was being flagged as a concern; however the procurement team were not being complacent and had the matter in their line of sight. She noted that this was a particular concern nationally and actions were being taken by HM Government.

The Chair's Report from Putting People First Committee was noted.

288 Chair's Report from Audit Committee

Ian Knight, Chair of the Audit Committee updated the Board on the work of the committee arising from the meeting held on 22 October 2018.

Referring to the report the Follow up of Internal Audit and External Audit Recommendations Report, Ian Knight reported on the assurance the Committee had received on completion of the actions and reported that the Committee had not identified any concerns arising from the report. Ian Knight advised on the five finalised reports internal audit reports and was pleased that of the five two had

received high assurance, one moderate assurance and the other two were not assessed for assurance purposes but had been noted that there were positive responses from the audit.

With regards to the Clinical Audit Annual Report 2017/18, Ian Knight reported that the Committee had received assurance that processes and procedures were in place that supported the undertaking of effective clinical audits and that action plans arising from the audits were being carried out appropriately.

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

289 Better Births compliance – Community Midwifery Update

Clare Fitzpatrick, Head of Maternity joined the meeting to present the Better Births Compliance and Community Midwifery Update paper. She explained that the paper provided an update on progress of the community redesign project and an update on the implementation of recommendations from the National Maternity Review "Better Births". The Head of Maternity advised that the community redesign sought to ensure that the Trust's services meet the needs of women and families, providing a service that offers choice, high quality, safe and effective care. Referring to the recommendations from Better Births, the Head of Midwifery advised that the aim was to improve outcomes of maternity services in England and was one of the key drivers in shaping the maternity service going forward.

The Head of Midwifery drew the Boards attention to the table on page 3 of the paper and referred to the amber rating for Continuity of Care (COC). She advised that the Trust was partially compliant due to recent recommendations and enhancement to the COC pathway, mandated by NHS England. The Head of Midwifery explained that in December 2017 the "Implementing Better Births: Continuity of Carer Report" set out guidance for Local Maternity Systems (LMS) to define and implement continuity of carer based on a local ambition and trajectory. She advised that to help generate momentum and ensure that the NHS was on track to deliver the ask that most women receive continuity of carer by March 2021, refreshed NHS Plans for 2018/19 required LMS to ensure that from March 2019, 20% of women at booking were placed on continuity of carer pathways and receive continuity of the person caring for them during pregnancy, birth, and postnatally. The Trust had submitted a Continuity of Care ambition and trajectory to Cheshire and Merseyside LMS that demonstrates the Trust was on track to deliver the requested 20% of women, by March 2019. The Head of Midwifery went on to explain the maternity care streams and how the Trust envisaged operational delivery of the mandated NHS E target, including community redesign.

The Head of Midwifery in summing up her report advised that a significant number of developments had been made to support the recommendations from the National Maternity Review as part of the community redesign. She explained that ongoing work across Cheshire and Merseyside partnership was intrinsically linked to the redesign of community services at the Trust and would continue to steer some of the work streams including: the implementation of continuity of care across the LMS; the development of community hubs; the development of digital applications; and the implementation of the single point of access to allow women to exercise choice over provider of care.

In response to a question on breast feeding rate, the Head of Midwifery reported that the Trust was achieving a rate of 64% which was an increase of 24% over previously reported rates. This success was due to way staff were obtaining an understanding what mums wanted and making sure that this was fed into implementation. She went on to explain that the Trust was one of the highest breast feeding performing trusts in the Country which was even more pleasing given the Trust was in a deprived region.

The Board noted the progress to date of the Better Births project arising from the National Maternity Review.

The Chair thanked the Head of Midwifery for an excellent paper and update and requested that the Board receive a further 6 monthly update in July 2019.

Action 2018/289: The 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 4 July 2019.

291 Emergency Preparedness, Resilience and Response (EPRR) Assurance Report

The Director of Operations presented the EPRR Assurance Report, advising that the report had been presented to the Finance Performance and Business Development Committee on 26 November 2018. He advised that FPBD had received assurance on the Trust's performance to date on delivery of the NHSE EPRR Core Standards and explained that under the guidance from NHSE, the Board was required to receive the Report following its journey through the Trust's governance processes.

The Director of Operations advised that as a category 1 responder under the Civil Contingencies Act 2004 (CCA) the Trust was required to prepare for emergency and business continuity incidents and ensure that it had the capability to respond to emergency situations and whilst managing emergency situations the Trust must as far as was reasonably practicable maintain business continuity, prioritising critical service delivery when necessary.

The Director of Operations reported that the annual assurance outcome of 'Substantial Compliance' against the NHSE EPRR Core Standards demonstrated that the Trust continued to be focused on meeting its duties under the CCA. He advised that current and continuing EPRR work streams including the 2018/19 Core Standards Action Plan aim to achieve a rating of 'full compliance' against the NHSE EPRR Core Standards for 2019/20.

The Director of Operations advised that of the fifty five EPRR Core Standards applicable to Specialist Trusts, the Trust met fifty three standards; the remaining two standards were partially met. He advised that an action plan had been developed and progress would be monitored towards completion of the two EPRR standards. The Director of Operations advised that the risk that either or both standards materialising was very low.

The Board received the annual assurance outcome of 'Substantial Compliance' against the NHSE EPRR Core Standards that demonstrated that the Trust remained focused on continuing to meet its duties under the CCA and to achieve a rating of 'full compliance' against the NHSE EPRR Core Standards for 2019/20.

292 Safer Nurse/Midwife Staffing Monthly Report Period 7 2018/19

The Director of Nursing and Midwifery presented the safer staffing report for month 7 and highlighted the key findings.

Referring to the inpatient wards fill rates during October 2018, the Director of Nursing and Midwifery advised that the average fill rate for registered staff in Gynaecology was lower than the previous month at 77.4% day time, however this increased to 97.85% during the night; the average fill rate non registered staff was 108.06% day time and 96.77% night time. This suggested that RGN gaps were substituted with HCSW for safety purposes during the day shifts, the gaps were due to staff waiting to commence in post and completion of supernumerary status. The Director of Nursing advised that currently across the Gynaecology wards there were 3 RGN vacancies.

The Director of Nursing and Midwifery reported that Maternity displayed the same fill rate as the previous month at 79.3%; however Maternity base was higher at 91.9%. She advised that the reason for the difference was due to an increase in short term sickness in October and waiting for new

starters commence work.

The Director of Nursing and Midwifery reported that safe staffing for each ward was assessed on a daily basis by the Divisional Matrons; the duty manager was responsible for the evenings and weekends within the divisions; and the on call senior manager had the responsibility for ensuring safe staffing of all ward areas across the Trust.

Referring to the red flags, the Director of Nursing and Midwifery advised that there were a total of eighteen incidents, reported under the Nursing/Midwifery red flag staffing criteria of which five incidents in total relating to staffing shortfalls across Gynaecology, Neonates and Maternity. The Director of Nursing and Midwifery reported that the main themes did not relate to staffing but were delays in induction due capacity issues within the department and lack of capacity in the Neonatal unit. Investigations into the two issues concluded that staffing levels and skill mix were safe at the time and did not contribute directly to any incidents.

Summarising the position, the Director of Nursing and Midwifery reported that during October 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. She advised that there had been a slight decrease in fill rate within inpatient maternity service; this was due to long term sickness, a spike in short term sickness, seasonal demands, maternity leave and vacancy rate. Recruitment within maternity was ongoing to address vacancy and maternity leave cover, 1:1 care in established labour remains a green KPI, and midwifery indicators such as Breast-feeding rates had seen an improvement in performance. Gynaecology continued to remain the focus for monitoring recruitment due to the National shortages of Registered Nurses and a recent increase in leavers. Reporting of incidents continue to be encouraged ensuring that red flags were discussed and acted on with the Gynaecology Head of Nursing and Management team.

The Chair thanked the Director of Nursing and Midwifery for her report which was noted and received assurance that the Trust had the appropriate number of nursing and midwifery staffing to manage the current activity.

293 Performance Report Period 7 2018/19

The Director of Operations presented the Performance Report for period 7 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 RTT performance had improved by 1% and was now delivering at 87%. Capacity continued to be an issue regarding consultant availability due to vacancies; however two new locum consultants had joined the Trust in October and this should provide much needed resource. Director of Operations explained that the locums would be concentrating on hysteroscopies to improve time to diagnose, and also providing additional capacity in general Gynaecology to reduce queues.

With regards to the use of Medinet as an outsource provider, the Director of Operations advised that all outcomes undertaken by Medinet consultants had been reviewed and were found to be positive with no issues identified. He explained that the Trust had paused additional work by Medinet as additional resource had been found internally. General Gynaecology consultants were also providing additional urogynaecology capacity and this would need to continue until the consultant vacancy post was appointed to; the Access Board had also agreed to extend the polling range from 6 weeks to 10 weeks and reported that FPBD had noted and agreed that this was a proportionate response.

Cancer targets remained a challenge, in particular with delays in receipt of histology results, resulting in delays in diagnosis. The Director of Operations advised that there was a national shortage of

available Histopathologists, which impacted on resource availability both internally and with the Trust's provider LCL; however with the additional internal Hysteroscopy capacity mentioned earlier would start to have a positive impact on time to wait for diagnostics. The biggest issue was that the Trust's provider of for histology results, LCL had vacancies which was resulting in delays in the provision of histology results of up to 14days.

In summing up the Report, the Director of Operations advised that the achievement of both RTT and Cancer targets were heavily reliant on providing sufficient consultant capacity to treat patients within the specified timeframes. He reported that the Trust was increasing capacity from a number of different sources until the permanent consultant recruitment was resolved. Urogynaecology sub speciality had the longest queues and waits for treatment and additional available capacity may still not be sufficient to fully address the issue. Extending the polling range to 10 weeks would improve patient access to an appointment but would have an impact on the achievement of 18 weeks for this sub speciality.

The Board noted the Performance Report for period 7 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.

294 Financial Report & Dashboard Period 7 2018/19

The Director of Finance presented the Finance Report and financial dashboard for month 7, 2018/19 and reported that at month 7 the Trust was reporting a deficit of £0.8m against a deficit budget of £2.2m, giving a year to date favourable variance of £1.4m. She advised that this was a sustained improvement and there was reasonable assurance that the control total would be met for the year; however the underlying position going into future years was a cause of concern referring to the acting as one contract with Liverpool CCG which provided £2.4m additional income earned YTD to Month 7, than would have been earned under PbR. She advised that this continued contract under-performance presents a significant financial risk to the Trust from 2019/20, and reminded the Board that work was underway to address this, through the 'Right Size' programme and Operational Planning.

In response to a question on the application of the CNST incentive payment, the Director of Finance reported that the criteria had not yet been published and it was too early to say whether the Trust would receive any benefit. She advised that the team would have to look very closely at the interpretation of the criteria given the differing views on interpretation encountered for the current financial year.

Referring to the Capital Expenditure profile, the Director of Finance reported that of the total £12.5m capital plan, £4.7m had been spent year to date, primarily on GDE Fast Follower infrastructure and implementation costs; a total of £1m had been spent year to date on the Neonatal Redevelopment. She explained that following agreement of the Guaranteed Maximum Price for the Neonatal redevelopment, the capital expenditure forecast for the programme for 2018/19 was revised to £3.9m against an original plan of £7.3m and consequently loan drawdown for the programme was revised accordingly.

With reference to the Board Assurance Framework, the Director of Finance advised that the reason to reduce the risk score for the "in-year risk to delivery of the annual plan 2018/19" was due to sustained over-performance against plan over a number of months, and the crystallisation and management of a number of key risks. She advised that this would be kept under close review over the coming months with a view to further reduction as the year progresses.

The Chair thanked the Director of Finance for presenting the Financial Report & Dashboard Period 7 2018/19 which was noted.

295 Operational Plan and Corporate Objectives – 6 monthly reviews.

The Board received the 6 monthly reviews of the Operational Plan and Corporate objectives noting that the Operation Plan review had been presented and reviewed at FPBD and that the Corporate Objectives had been reviewed by each of the Board committees (FPBD, Quality Committee and PPF).

The Board noted that both reviews were a very good reflection of the Trust's activity and delivery of the Operational Plan and Corporate objectives over the first half of the financial year.

The Board noted the performance against the Operational Plan and Corporate Objectives 2018/19 for the first 6 months of the financial year 2018/1.

296 Future Generations

The Medical Director & Deputy Chief Executive provided an update on the current position and reported that as yet the Trust had not received notification of the decision from the Secretary of State for Health and Social Care regarding its application for capital funding for the new build on the university campus Site. He reminded the Board that once approval for capital funding was received Liverpool CCG would be able to progress to public consultation subject to NHS England approval. He recognised that there was no certainty that the Trust would be successful in its application.

The Medical Director & Deputy Chief Executive advised that meetings had continued with external stakeholders and reported on the very positive meeting he and the Chief Executive had with Steve Rotheram, Metro Mayor for the Liverpool City Region who had lent his support to the clinical case for change. The Medical Director & Deputy Chief Executive further reported on the meetings held with the Royal College of Nursing and Midwifery and the union UNISON, both of whom had also supported the clinical case for change.

The Chair thanked the Medical Director & Deputy Chief Executive for the update.

297 Board Assurance Framework

The Board considered the Board assurance Framework (BAF) and noted actions taken by the Board Committees to review each of the risks within their remit.

The Board noted and approved the reduction of the risk score relating to the corporate risk "delivery of the annual plan 2018/19" to 20 by reducing the likelihood of the risk from 5 to 4 and received assurance from the Board Assurance committees that the risks were being properly managed.

298 Review of risk impacts of items discussed

The Board noted that no additional risks had been identified during the meeting.

299 Any other business & Review of meeting

The Chair noted that the Label 1 had been wrapping up filming for the Hospital documentary and that it would be aired on BBC2 in January 2019.

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 1 February 2019.

Agenda Item 2019/005

Liverpool Women's NHS Foundation Trust

TRUST BOARD
7 December 2018 Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
7 December 2018	2018/289	The 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 4 July 2019	Director of Nursing and Midwifery	4 July 2019	

	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	2019/007

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Chief Executive Report**
DATE OF MEETING:	Friday, 01 February 2019
ACTION REQUIRED	**For Noting**
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	Colin Reid, Trust Secretary
STRATEGIC OBJECTIVES:	***Which Objective(s)?***
	1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒
	2. To be ambitious and *efficient* and make the best use of available resource ☒
	3. To deliver *safe* services ☒
	4. To participate in high quality research and to deliver the most *effective* Outcomes ☒
	5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***
	1. *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust……* ☒
	2. *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

Flu **campaign** – The Trust had at the end of December met the CQUIN target of 70% for staff inoculations. .

BJM Awards 2019: I am delighted to inform you that Carol Murray, Infant Feed Adviser has been shortlisted as a finalist in the BMJ awards in the **Midwife or peer supporter in improving breastfeeding**' category. Well done Carol.

Hospital Documentary: The BBC's Hospital series started on Thursday 10th January 2019, which runs for six episodes and focusses on a number of Trust's in Liverpool. The weekly audience figures for the first two episodes was on average 2million each week. Liverpool Women's episode aired on 24th January 2019 at 9pm on BBC2 (now available to catch up on the BBC iPlayer). It featured four patient stories across three of our services; Maternity, Gynaecology, and the Neonatal Unit. The episode also focussed on why we need to change our services for the future by moving to a new hospital next to the Royal. The response to the episode has been fantastic and the

comments and compliments of our services on social media has been extremely positive. As a result we have seen an increase in the number of visits to our website; particularly our recruitment page, how to get involved with the Trust, and the sections which explain our need for change in the future. There is expected to be continued viewings of the episode via catch up services for the rest of the series which is scheduled to end on 14th February 2019. The Trust's Communications Team will be producing a detailed impact report to breakdown the statistics and comments received over the next few weeks.

Dedicated to Excellence Awards 2019: Entries to the Dedicated to Excellence Awards 2019 are now OPEN. We have 10 categories for you to enter this year, many of which you will recognise from previous years.

- **Dedicated to Innovation and Improvement (clinical)**
- **Dedicated to Innovation and Improvement (non-clinical)**
- **Dedicated to Working together (team working and partnerships)**
- **Dedicated to Research**
- **Dedicated to Patients and their Families**
- **Dedicated to Patient Safety**
- **Dedicated to Clinical Audit**
- **Staff Fundraiser of the Year**
- **Mentor of the Year**
- **Learner of the Year**

There will also be the following categories, entries to which are already made up of monthly award winners throughout 2018/19:

- **Employee of the Year**
- **Team of the Year**
- **Volunteer of the Year**
- **Foundation Award**

Our online digital form is back again this year. It's quick and easy to use, allowing you to enter on site or at home. Simply select the category you want to enter into from the drop down menu and complete the form as directed. Enter now here

The criteria is not on the form but can be found here . It is important you use this when completing your form. The judges score all the entries based on how well they met the criteria. So to get top marks link your entry back to the criteria.

Patient Choice Award - Entries to the Patient Choice Award are also open! Please encourage family and friends who have received great care here, to nominate the member of staff or team who looked after them! We want to celebrate as many staff as possible. Please nominate here

Copies of the nomination form for the Patient Choice Award should be placed within your working areas.

Deadline for entries is Friday 1st March

Fair and Just Culture Update January 2019 : The first cohort of 6 senior leaders from a range of departments have visited the USA and undertaken certificated training in Fair and Just Culture principles and implementation. All participants have successfully completed a 2 hour exam. The course was an exciting opportunity to meet organisations and individuals already involved in implementation of a Fair and Just Culture. The second cohort of 4 people will leave for Vienna, on 28th January 2019 and not only will they achieve certification in Fair and Just Culture they will be able to attend a Train the Trainers course which will then enable us to develop full a training plan for LWH staff in the principles of a Fair and Just Culture. A steering group is being set up with representatives from different areas of expertise and this will begin in earnest after the second round of certification training has

been completed. This steering group will agree the project plan, work streams and timeframes, which will be presented to the PPF committee in March 2019.

Genomics National Re-configuration of Laboratories: Work to reconfigure the North West Genomic laboratories is continuing to take place with de-duplication of genetic tests now scheduled to go live after 1st April 2019. Interviews for the three key senior positions of Medical Director, Scientific & Academic Director and Scientific Operations Director are scheduled to take place on 17th January 2018. It is expected that once the successful individuals are appointed, the shape of the future workforce model will be clarified and further communication with staff regarding the transfer of their employment to Manchester Foundation Trust under TUPE can commence. This will take place on 1st April 2019.

Apprenticeships : The range and level of apprenticeships continues to expand. The Trust is exploring the possibility of commencing training and employing Nursing Associates, hopefully being able to access additional funding to support training

Information Commissioner Referral : Two members of staff from the same department submitted a written complaint to the Information Commissioners' Office stating that their personal files had gone missing. Following investigation, the ICO's ruling was that we should revise our policies and procedures regarding personnel records and ensure that we are able to audit when information is added or removed. In response to that decision, a project has been initiated with Russell Cowell (Head of Confidentiality, Data Protection and Compliance) and Simon Davies (HR Manager) looking at how these issues can be addressed. They are looking at how the EDMS system could be used for the Trust's personnel records. This would give us a fully electronic solution with one single electronic file for each employee, with sub-folders so that we can control what local managers have access to and what we in HR would have access to. This would also be auditable so that when information is added or removed we could track who had actioned that and when. A draft proposal will be completed by the end of this month."

SECTION B – Local

Liverpool Health Partners: Following national advertisement and an open recruitment process, Neil Goodwin has been appointed Chair of Liverpool Health Partners. This is a substantive post. Additional to this the attached set out appointment to the LHP team.

SECTION C – National

1. NHSI/E director appointments

NHSI/E has announced the names of the seven newly appointed joint regional directors for NHS England and NHS Improvement as follows:

- **South West** – Elizabeth O'Mahony, currently NHSI's chief financial officer.
- **South East** – Anne Eden, already joint NHSE and I regional director for the South East.
- **Midlands** – Dale Bywater, currently NHSI's regional director for the Midlands and East.
- **East of England** – Ann Radmore, currently Kingston Hospital Foundation Trust chief executive.
- **North West** – Bill McCarthy, currently deputy vice chancellor at Bradford University and chair of Bradford Teaching Hospital Foundation Trust and a former NHS England and Department of Health executive director.
- **North East and Yorkshire** – Richard Barker, currently NHSE's director for the North of England.
- **London** – Sir David Sloman, currently Royal Free London Foundation Trust.

NHSI/E has also announced the appointment of the following national directors:

- Julian Kelly, who has been director general within the Ministry of Defence's nuclear division since May 2017, is due to take up the joint chief financial officer post by April 2019.
- Professor Stephen Powis will be medical director, having been in this role for NHSE since the start of 2018. Ruth May will be chief nursing officer, having been executive director of nursing at NHSI since 2016.
- Matthew Swindells, NHSE's director of operations and information since 2016, will be deputy chief executive, while Pauline Philip will be director of emergency and elective care, having been jointly employed in a similar role since 2015.
- Ian Dodge will be director for strategy and innovation and Emily Lawson will be director for transformation and corporate development, having both performed these roles for NHSE.

Recruitment is ongoing for the posts of chief provider strategy officer, chief people officer, chief commercial officer and chief improvement officer. Well known figures including NHSI's deputy CEO and executive director of regulation Stephen Hay, NHSI's executive medical director and chief operating officer Dr Kathy McLean and NHSI's executive director of improvement Adam Sewell-Jones are stepping down or moving to new opportunities.

2. Brexit developments

On 21 December 2018 the Department of Health and Social Care (DHSC) issued EU Exit Operational Readiness Guidance which has been developed and agreed with NHS England and NHS Improvement. The guidance sets out the local actions which providers and commissioners of health and social care services in England should take to prepare for EU Exit in the event of a 'no deal' scenario. The guidance seeks to ensure that organisations are prepared for, and can manage, the risks in such a scenario.

The following 7 key areas are addressed

- supply of medicines and vaccines;
- supply of medical devices and clinical consumables;
- supply of non-clinical consumables, goods and services;
- workforce;
- reciprocal healthcare;
- research and clinical trials; and
- data sharing, processing and access.

Providers and commissioners have been issued with a series of action cards to help address and identify emerging issues and risks in these areas.

An operational response centre has been established by DHSC to support the heath and care system to respond to any disruption. ***The Director of Finance has been nominated as the Senior Responsible Officer for EU Exit Preparation for Liverpool Women's NHS FT***.

3. NHS Providers Planning Guidance and control totals 2019/20 – See attached briefing note.

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 21st January 2019

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

2. **Agenda items covered**

~ **Operational Performance Month 9 2018/19 including RTT and Cancer Targets:** The Committee received Month 9 performance dashboard and noted that RTT performance had stabilised at 87% and the backlog queues are also being maintained at around 600. It was anticipated that RTT backlog queues would fall to zero by the beginning of March 2019. Cancer targets were showing signs of improvement supported by weekly provisional figures for January. Further work is required in reducing the waiting time to diagnosis. The Committee noted that it was unlikely the Trust would be delivering 62 day cancer target by 31 March 2019.

~ **Finance Performance Review Month 9 2018/19 including CIP:** The Committee received Month 9 2018/19 finance position. At Month 9 the Trust was reporting a year to date (YTD) deficit of £0.3m against a deficit budget of £2.4m, giving a year to date favourable variance of £2.1m. The Committee was assured that this was a sustained improvement and consequently the forecast position at year end has improved by £0.5m on a non-recurrent basis. The Committee noted the assumption that an additional £0.5m of Provider Sustainability Fund (PSF) income would be made available as a consequence of the improved position; overall revised deficit forecast of £0.6m before PSF bonus. The 'Acting as One' block payment for 2018/19 has created £3.4m of additional income earned YTD to Month 9, than would have been earned under PbR and the Committee recognised the significant financial risk this represented to the Trust from 2019/20. The Committee received and update on the work being carried out to address the risk which was via the 'Right Size' programme and Operational Planning.

The Committee noted that recurrent CIP programmes for 2018/19 were behind plan and received assurance that non-recurrent mitigations had been found to address the in-year shortfall.

The Committee noted that the Trust was on target to deliver a better than plan control total for 2018/19 and agreed to reduce the risk score for BAF risk delivery of the "delivery of the annual plan 2018/19" to 15.

~ **Strategic Outline Case Update:** The Committee received an update on the decision for the capital funding for the proposed new build and noted that although the Trust had been informed through the Cheshire and Merseyside Health and Care Partnership that the application had not been successful; formal notification from the Secretary of State for Health and Social Care had not yet been received but was expected soon following which the Trust would be able to consider its next steps.

NHS

- **Operational Plan 2019/20:** The Committee received a presentation on the production of the Trust's Operational Plan 2019/20.

- **EPR Update:** The Committee received an update on the current status of the EPR programme and the risks and challenges being faced.

- **Treasury Management Report –** The Committee received assurance that the Treasury Management processes in the Trust continued to operate effectively and that overall the Trust had a stronger cash position than planned due to an improved income and expenditure position and favourable working capital movements.

- **BREXIT arrangements update:** The Committee were informed of the recent publication received from the Department of Health and Social Care (DHSC) that provided trusts with an "EU Exit Operational Readiness Guidance". The Committee noted that the guidance provides local actions which providers and commissioners of health and social care services in England should take to prepare for EU Exit in the event of a 'no deal' scenario. The Committee was assured that the guidance was being considered by the Trust noting that the Director of Finance had been nominated as the Trust's Senior Responsible Officer for EU Exit Preparation.

- **Neonatal Redevelopment Project:** The Committee received an update on the status of the Neonatal Redevelopment Project, noting that the project was on track and that the risks costs were being managed to bring the total spend within budget.

Board Assurance Framework (BAF) risks reviewed

- The Committee reviewed the BAF risks and agreed to the changes recommended in the paper. With regard to the current risk level for the "delivery of the annual plan 2018/19" the Committee agreed to reduce the risk score to 15 by reducing the likelihood of the risk from 4 to 3 and recommended this to the Board for approval.

- **Sub Committee Chairs reports received:**
  - Turnaround and Transformation Committee
  - Digital Hospital Sub-Committee

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

Jo Moore
Chair of FPBD
January 2019

Liverpool Women's NHS Foundation Trust

2019/009

Board of Directors

Committee Chair's report of Audit Committee meeting held 21st January 2019

1. Meeting Quorate: Yes

2. Agenda items covered

- Follow up of Internal Audit and External Audit Recommendations: The Committee received an updated position on audit recommendations. It was noted that there were currently there are currently 14 outstanding but not yet due audit recommendations The Committee raised no concerns.
- Internal Audit Progress Reports: The Committee received two finalised reports: Conflict of Interest (Substantial Assurance) and Risk Management Review (Substantial Assurance). Agreed management actions had been identified in the reports.
- Anti-Fraud Progress Report: The Committee received a progress report and noted the activity undertaken by the Anti-Fraud Service (ASF) in the Trust which included delivery of face-to-face fraud, bribery and corruption awareness presentations at the Trust's monthly corporate induction. New starters are also provided with written awareness materials within their induction pack. The Committee also noted that a fraud awareness all-staff survey has been provided to gauge staff awareness and identify any areas to inform awareness activities going forward.
- MIAA Insights Briefing: The Committee noted the events and benchmarking update.
- Year-end Issues/Judgements 2018/19: The Committee noted the areas in the 2018/19 accounts requiring the judgement of management. The Committee approved the approach that the accounts should be prepared on a going concern basis and noted the areas of judgement. A further update would be presented at the March Committee meeting.
- Production and Submission Annual Reports and Accounts 2018/19: the Committee received and noted the internal timetable for the production of the Trust's Annual Reports and accounts 2018/19 and the submission timings to NHS Improvement and Parliament. The Committee were assured that there was evidence that the data quality highlighted in the Annual Governance Statement last year was had been or was being obtained surrounding RTT and 62 day cancer. It also noted that the limited assurance audit that would be carried out by the external auditor in relation to the Quality Report 2018/19 included NHSI mandatory quality indicators for RTT and 62 day cancer.
- External Audit Plan: the Committee received the External Audit Plan for the audit of the Trust's Annual Reports and Financial Statements. The Committee noted that there had been no significant changes to the approach to Audit from the previous year. KPMG advised that the materiality level had been set at £1.75m (1.5% of revenue) 2017/18 it was set at £1.5m (1.3% of revenue). KPMG identified three significant opinion risks: valuation of land and buildings; revenue recognition; and management override of control. Other areas of focus were: new accounting standards and going concern. The Committee also recognised a risk to the migration of the Trust's financial systems from the current Oracle software to Oracle Cloud.

  With regards to the Quality Report Audit, the Committee noted that NHS Improvement had mandated the same two 2 quality indicators for audit: RTT and 62 Day. The Committee noted

NHS

that the Governors were also required to select a quality indicator as previous years and a selection would take place at the Governors Quality and Patient Experience Group meeting on 18 February with ratification at the Council meeting on 20 February.

- Register of Waivers – The Committee noted that there were 23 waivers raised in Q3 2018/19 with a combined value of £473k; the value being impacted by one specific waiver which the Trust undertook full due diligence before agreement. This was an increase on the levels raised in Q1 and Q2 of 2018/19 and the same period in 2017/18 (14, £194k). The Committee received assurance that the increase in waivers achieved savings or were for due to a number relating to either sole supplier, standardising products in use or where the product or service was required urgently.
- Managing Conflict of Interest: The Committee noted the Trust registers held on the Trust website disclosing Trust Directors, Governors, Staff and Clinician outside interests. The Committee were satisfied that the process for obtaining disclosures was appropriate, taking into account the substantial assurance received from MIAA as reported earlier in the meeting.
- Chairs Reports – The Committee noted that there were no concerns raised regarding the integrated governance processes in place within the Trust and that matters were escalated in accordance with Board requirements.

3. Board Assurance Framework (BAF) risks reviewed

- None

4. Issues to highlight to Board

- None

5. BAF recommendations

- None

6. Action required by Board

- None

Ian Knight
Chair of Audit Committee
January 2019

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Quality Committee meeting held 22 January 2019

1. Was the quorate met? Yes

2. Agenda items covered

~ Subcommittee Chairs reports:

- Safety Senate held 11 January 2019
- Effectiveness Senate held 18 Jan 2019
- Experience Senate held 11 December 2019
- Hospital Safeguarding Board held 11 December 2019 (taken under Safeguarding agenda item)
- Corporate Risk Committee held 17 January 2019

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

~ Board Assurance Framework – Quality Related Risks: The Committee reviewed the Quality related BAF risks. No changes have been made to the risk scores for each of the BAF risks the Committee has responsibility for. The amendments have been made to the "Potential for poorly delivered positive experience for those engaging with our services" risk, in relation to the "controls" in place to manage the risk, the removal of elements in the "gaps in control" and the removal of action plans that had been delivered.

~ CQC Inspection Action Plan: The Committee received assurance on the progress against the CQC inspection action plan and discussed plans moving forward.

~ Monthly Quality Performance Review M9: The Committee noted the contents of the Monthly Quality Performance Report and received an update in delivery of the RTT and Cancer targets. The Committee noted that RTT performance had stabilised at 87% and the backlog queues are being maintained at around 600. It was anticipated that RTT backlog queues would fall to zero by the beginning of March 2019. Cancer targets were showing signs of improvement supported by weekly provisional figures for January. Further work is required in reducing the waiting time to diagnosis. The Committee noted that it was unlikely the Trust would be delivering 62 day cancer target by 31 March 2019. The Committee noted that the Trust had received data quality validation relating to RTT and Cancer via two audits undertaken by separate independent organisations brought in following the reporting of the SIs in 2018.

~ Serious Incidents and Learning Q3 Report: The Committee received assurance on the serious incidents reported in Q3 and discussed the overdue SI actions. The Committee received assurance that the two actions relating to Maternity had been completed appropriately.

~ Research and Innovation Strategy and Review: The Committee received an update on the Research and Innovation Strategy and received assurance on the progress demonstrated to date, particularly in respect of delivering of the Joint Research Service and agreement of Consultant Research PAs. Further efforts would intensify during 2019 to develop and implement the aims and objectives of the strategy.

~ Safeguarding Annual Report 2017/18: The Committee received a presentation on the Safeguarding Annual Report 2017/18 which was well received and the Committee recommends

that it is approved by the Board at the Board meeting on 1 February 2019. The Committee also received an update on the 2018/19 objectives and were assured that the Safeguarding team were on target to deliver the objectives.

Referring the Chairs report from the Hospital Safeguarding Board meeting on 11 December 2019 concerns were expressed in the report regarding a recent CQC Inspection of Safeguarding Services commissioned by Sefton CCG. The Committee noted that throughout the CQC inspectors reported on the robust and positive working practices and procedures of the Trust's Safeguarding Team. The Committee noted that some of the findings were not as positive for some other providers in the Sefton commissioned area. The CQC report makes recommendations supporting the need for providers to share the same or similar processes to provide greater assurance to Sefton CCG. The Committee asked that a report be presented to the Board setting out the consequential issues for the Trust at the Board on 1 February 2019.

~ **Seven Day Acute Services work into the Board Assurance:** The Committee noted the new requirements regarding the future board assurance framework for Seven Day Acute Services. The Committee noted that NHSI will pilot the new system from the end of February 2019, a report on the findings will be brought back to the Committee in March 2019 with a paper to the Board in either April or May 20919.

3. **Review of risk impacts of items discussed:**
Electronic Patient Records – The Committee noted the current risks to the implementation of the new EPR.
Future Generations - Failure to secure capital funding for the new hospital build.

4. **Escalation report to the Board on Quality Committee Performance Measures**
None.

5. **Issues to highlight to Board**
Safeguarding annual Report 2017/18 for approval.
Sefton CCG CQC Report

6. **Amendments to the Board Assurance Framework**
There are no changes to the risk scores recommended for approval by the Board. Textural amendments have been made to the "Potential for poorly delivered positive experience for those engaging with our services" risk, in relation to the "controls" in place to manage the risk, the removal of elements in the "gaps in control" and the removal of action plans that had been delivered, which were agreed by the Committee.

7. **Action required by Board**
None.

Susan Milner
Chair of Quality Committee
January 2019

Liverpool Women's NHS Foundation Trust

Board

Chair's report of Putting People First Committee meeting held 25th January 2019

1. Was the quorate met?

Yes

2. Agenda items covered

~ Board Assurance Framework – the 2 workforce BAF risks were reviewed and it was confirmed that there were no amendments.

~ Staff Experience Story – presented by Gillian Walker, Matron, Gynaecology. Gillian talked about her journey over the last 12 months and some of the difficulties she had experienced during this time but also about the positive changes that were now being seen with the appointment of the new senior leadership nursing team.

~ Service Assurance Workforce Reports – Gynaecology and Hewitt Fertility Services. Both reports highlighted the workforce challenges for the coming year. The main issues being; succession planning in response to the ageing workforce profiles, initiatives to increase staff morale and redefining roles and responsibilities within the senior nursing roles. The Committee was assured that there were appropriate plans in place to main workforce risks.

~ NHS Long Term Plan, Workforce Implications – an overview was presented of the key workforce challenges set out in the Plan and a brief update provided of the Trust's initial responses to these. The Committee was assured that the Trust was well sighted on the key challenges ahead and these were appropriately reflected in the Workforce Strategy.

~ Director of Workforce Report – key highlights included; an update on the OCS potential threat of industrial action, the impact this may have on services and the need to manage the risk of reputational damage; and the outcome of an ICO referral made in 2018 relating to personal files held by a manager. Assurance was provided in relation to the review of processes and update of guidance to managers, and the potential to move to e-files.

~ EU Exit Operational Readiness Guidance – The Committee was assured that there were no significant workforce risks to the Trust arising from Brexit.

~ Workforce KPI's – the workforce KPI's were reviewed, It was noted there had been a 1 month breach in the "time to hire" target in November 18 but assurance was provided that this had been addressed through the contract management of the service. No further breaches are anticipated. The Committee sought a detailed report on clinical mandatory training for the next meeting.

~ GMC Survey Findings – the Director of Medical Education provided a summary of the findings of the annual survey taken in relation to the training provision for trainees and the actions being taken to respond to the feedback from trainees.

NHS

- Bi-annual Nursing & Midwifery Staffing Report – the Director of Nursing & Midwifery provided a comprehensive report for the period June – December 2018. The Committee noted the assurance provided that staffing levels were appropriate and safe. A review of headroom was being undertaken as part of budget setting processes.

- Guardian of Safe Working Hours Q3 Report – no exception reports were reported during this period. Additional education is being undertaken with the junior doctor workforce to encourage reporting. It was noted that the number of gaps on the rotas is likely to increase in the coming months and that work was on-going to mitigate these.

- Sub Committee Chair Reports – Chair Reports received from; NHSI Sickness Improvement Project Group, Education Governance, Diversity & Inclusion, Partnership Forum, Health & Wellbeing

- PPF Business Plan Cycle 2019/20 – plan agreed for next 12 months

3. Matters to be highlighted to the Board
The Committee was advised that UNISON has escalated the potential of industrial action by OCS staff. The ballot on action will close 1st February 2019. The Trust has commenced contingency planning.

4. Escalation report on Performance Measures discussed
None

5. New risks identified/action taken/escalation to BAF
It was agreed to review the overarching risk to service delivery associated with an ageing nursing workforce.

6. Amendments to the Board Assurance Framework
None

7. Learning identified for dissemination within the Trust
None

8. Action required by Board
None

Tony Okotie
Chair of Putting People First Committee
Date: 25th January 2019

Agenda Item	2019/12(1)

MEETING	Board of Directors
PAPER/REPORT TITLE:	**Safeguarding Annual Report 2017/18**
DATE OF MEETING:	1 February 2019
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	**Caron Lappin** **Director of Nursing & Midwifery / Executive Lead for Safeguarding**
AUTHOR(S):	**Mandy McDonough, Associate Director of Nursing and Midwifery for Safeguarding**
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** **1.** To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☐ **2.** To be ambitious and ***efficient*** and make the best use of available resource ☐ **3.** To deliver ***safe*** services ☒ **4.** To participate in high quality research and to deliver the most ***effective*** Outcomes ☐ **5.** To deliver the best possible ***experience*** for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☐ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☐ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☐ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good*

	outcomes, ☐ *promotes a good quality of life and is based on the best available evidence.* ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity* ☐ *and respect.* ***RESPONSIVE –*** *the services meet people's needs.*☐ ***WELL-LED -*** *the leadership, management and governance of the* ☐ *organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ***ALL DOMAINS*** ☐	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☒	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other:
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***To note an overview of safeguarding practice across the Trust and receive assurance that systems and processes are in place to protect vulnerable Children and Adults***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	
	Date of meeting	

Executive Summary

All NHS bodies have a statutory duty to make arrangements to safeguard and promote the welfare of children and adults. There is a particular emphasis placed on organisations to provide a greater assurance to the Board of Directors and external partners that those at the greatest risk of abuse are safeguarded as appropriate. To that end, Safeguarding remains a fundamental component of all care provided within Liverpool Women's NHS Foundation Trust (LWFT) and this year has again been both exciting and challenging in respect to ensuring that we respond effectively and efficiently to the challenges of safeguarding both our patients and our staff.

The purpose of this report is to provide an overview of Safeguarding activity within the Trust for the period 1st April 2017 – 31st March 2018 and to assure our Board of Directors that the Trust has effective systems and processes in place to safeguard patients who access services in the Trust. The report demonstrates that the Trust is meeting its statutory and commissioned responsibilities in relation to safeguarding children and adults.

The report will highlight that it has been another busy 12 months, with an increase in our referral rates into the Team. However, much has been achieved in this reporting period with regards to our key safeguarding activities; and again this year, in recognition of our continued progress and reputation, we were commissioned by other provider Trust to undertake a Peer Review of their Safeguarding services in preparation for an imminent CQC Inspection.

Following on from the review of Aintree Foundation NHS Trust in August 2017, under the terms of a Service Level Agreement (SLA), LWFT provided key personnel in order to support their existing structure in respect to specific statutory and contractual obligations relating to Safeguarding. This work enabled the development of a Strategy and accompanying Improvement Plan for Aintree which would ensure the Trust could demonstrate assurance to NHS Regulators and Commissioners regarding their ability to comply with statutory and contractual Safeguarding requirements.

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

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

to safeguard children and adults and will be supported by the Hospital Safeguarding Board.

Board Approval

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

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

Caron Lappin
Director of Nursing & Midwifery / Executive Lead for Safeguarding

Contents

Introduction

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

'Safeguarding Mission Statement'

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

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

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

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

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

Maintaining the function and quality of all aspects of safeguarding practice across the Trust is essential; with a particular focus on ensuring effective strategic Safeguarding leadership is in place.

The Team have continued to implement relevant Safeguarding processes and recommendations in conjunction with continuing financial austerity and change across other partner agencies; establishing robust governance and assurance processes and embedding a continually developed Safeguarding Strategy.

Summary of Current Position

Throughout the reporting period for 2017/18, significant progress has been made with the safeguarding adults and children's work plans and our overall Trust objective, which was to:

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

Key areas of priority were identified and reported in the Safeguarding Annual Report 2016/2017 and progress against these areas has now been completed. The key priorities were as follows:

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

- ✓ Ensure the provision of quarterly Key Performance Data (KPI's) to our commissioners and performance data to our external agencies/partners regarding service delivery relating to safeguarding issues

- ✓ Provide expert advice and strategic direction to Liverpool Women's NHS Foundation Trust Chief Executive, Director of Nursing and Midwifery, Board of Directors, Managers and Clinicians as required on Safeguarding in accordance with National and Local policy and in the best interest of the reputation of the Trust

- ✓ Building on the Safeguarding Team's already established processes, compliant with legislation, further develop Liverpool Women's collaborative vision for safeguarding across provider organisations

A number of areas will remain ongoing and added to future work plans, as they are core components of providing the necessary assurance. The key objectives for 2018/2019 will be summarised at the end of this report..

Safeguarding Governance

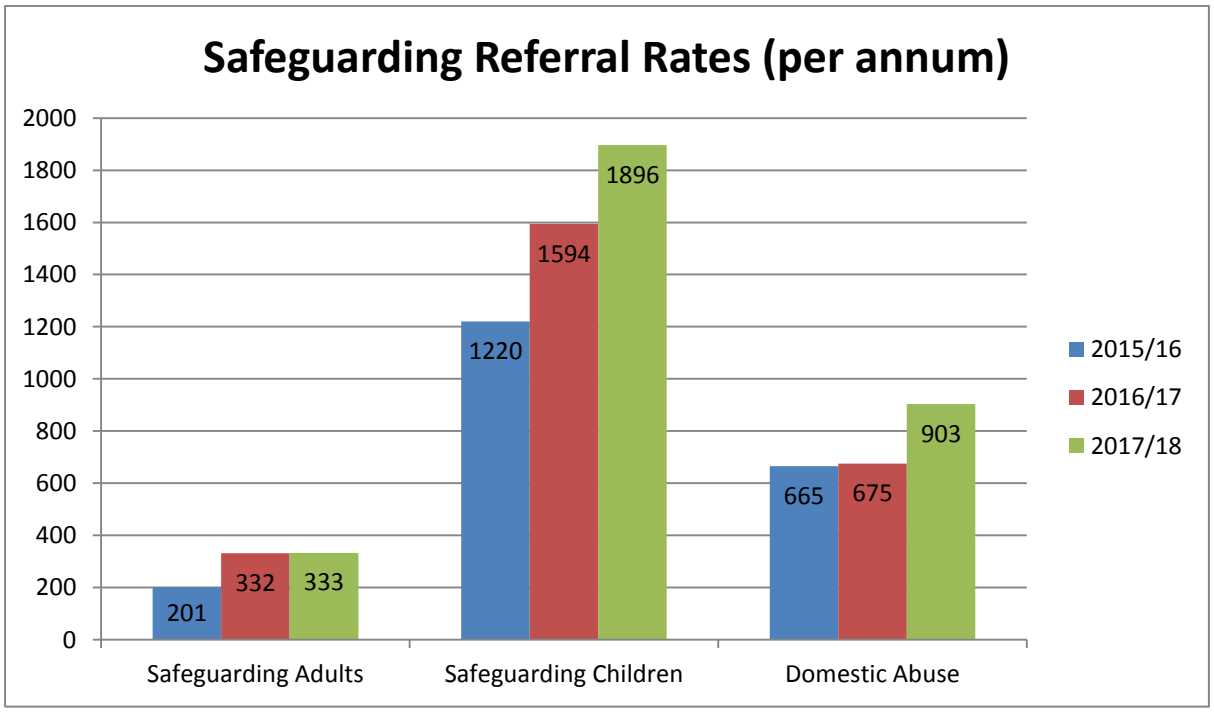
Risk

Safeguarding Risk Register

Risk item 1732, originally on the Trust BAF scored as a 20 (in December 2014) was reduced to a score of 9 during 2016/17 and managed on the Safeguarding Risk Register (Risk item 1895). This continued to be monitored by HSB with two outstanding actions at the start 2017/18. However with the implementation of Child Protection Information Sharing (CP-IS) and the launch of the multi –agency Harmful Practices Protocol during the year, these actions were completed and the risk was subsequently closed.

Performance

Safeguarding Performance Data



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

The CCG monitor all areas of safeguarding performance, ensuring accurate assurance can be evidenced. These include:

1. Training
2. Governance

3. Partnership working (multi-agency)
4. Safeguarding Supervision
5. Annual Audit Tool

At the end of 2017/18, LWFT were awarded significant assurance across all areas assessed, apart from training. This was due to a reduced compliance for Level 4 safeguarding Children and Adult Training. This has led to some ongoing work with Learning and Development around the accuracy of the Trusts training reports.

Local Safeguarding Children Board (LSCB) Section 11 Audit

Section 11 of the Children Act (2004) places duties on a range of organisations and individuals to ensure their functions and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

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

Following the submission in 2016/17, LWFT have continued to update the system throughout the year ensuring accurate recording and Section 11 compliance. All information has been made available to Liverpool, Sefton and Knowsley Safeguarding Boards and forms the basis for the Board Leads apply scrutiny to LWFT's processes in accordance with the Children Act (2004). The Associate Director of Nursing and Midwifery for Safeguarding attends the Scrutiny Panel's when required and provides the relevant assurance on behalf of the Trust.

Governance

Policies

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

Updated documents in 2017/18:

1. Safeguarding Children Policy
2. Safeguarding Adults Policy
3. MCA/DoLS Policy

4. Supporting Patients with a Disability Policy
5. Prevent Policy
6. Domestic Abuse Policy
7. Children treated in an Adult Healthcare Setting Policy
8. Missing Child Guideline
9. Safeguarding Training Strategy

Assurance

Hospital Safeguarding Board (HSB)

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

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

In this reporting period, the HSB has focused on monitoring progress with CCG compliance and multi-agency engagement with external partners.

We have also completed a review of the Terms of Reference in which the body of work encompassed within the HSB was clarified ensuring the following items are continually discussed and monitored:

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

Safeguarding Operational Group (SOG)

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

MIAA

As part of our 2017/18 audit plan, MIAA undertook a review of the arrangements for Safeguarding children and vulnerable adults at Liverpool Women's NHS Foundation Trust; reporting significant assurance in these arrangements.

The review found that there was visible commitment from the Trust Board around the importance of effective safeguarding systems and processes and the absolute requirement to operate in line with the safeguarding requirements of the Trust's provider license.

Our external stakeholders confirmed that they were satisfied with the Trust's Safeguarding arrangements and were extremely positive about the responsiveness, openness, multi-agency engagement and partnership working and visibility of the Safeguarding Team.

Overall findings highlighted good practice arrangements for Safeguarding within the Trust; including:

- ✓ Safeguarding policies, operating protocols and procedures
- ✓ Training Strategy and TNA
- ✓ mandatory training compliance
- ✓ robust processes for governance and performance
- ✓ significant assurance ratings from commissioners and Safeguarding Boards
- ✓ evidence of lessons learned and continuous improvement
- ✓ clinical audit

Although the report highlighted our processes as effectively able to achieve the objectives of a Safeguarding Service, it also identified due to imminent large scale

projects (e.g. EPR) further process change will be required to continue to support staff effectively.

Care Quality Commission (CQC)

The CQC completed their inspection of the Trust between the 29th January 2018 and the 28th February 2018, resulting in an overall rating of Good. This rating had stayed the same from the Trusts previous inspection in 2015.

With particular regard to Safeguarding arrangements, the CQC rated the Trust as Good because:

- Safety systems, processes and standard operating procedures were reliable or appropriate to keep women and babies safe. Staff followed policies in line with national guidance.
- The Trust identified and assessed patient risk well. When staff identified risks to patients, appropriate measures were taken to mitigate these risks.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service had enough staff with the right qualifications, skills, experience and training to keep patients safe from avoidable harm and abuse, and to provide them with the care and treatment they needed. Ward managers matched staffing levels to patient need and could increase staffing when care demands rose by rotation of staff.
- The trust provided specialist clinics and staff with enhances skills to support women with special needs
- Safeguarding adults, children and young people at risk was given sufficient priority. Staff took a proactive approach to safeguarding and focus on early identification. They took steps to prevent abuse or discrimination, responded appropriately to any signs or allegations of abuse and worked effectively with others, including people using the service, to agree and implement protection plans.
- Since our last inspection there was significant improvement in safeguarding training compliance levels.
- Community staff made prompt and timely referrals for women and babies that were identified as vulnerable and there was evidence that the trust worked closely with the enhanced midwifery team, Safeguarding Team and social services

Training

The Trusts compliance levels for Safeguarding training at the end of the 2017/18 period are:

Session	CCG Compliance Threshold (%)	Compliance as of April 2018 (%)
Safeguarding Children Level 1	90%	**93%**
Safeguarding Children Level 2	90%	**93%**
Safeguarding Children Level 3	90%	**90%**
Safeguarding Children Level 4	90%	**100%**
Safeguarding Adults Level 1	90%	**93%**
Safeguarding Adults Level 2	90%	**93%**
Safeguarding Adults Level 3	90%	**66%***
Safeguarding Adults Level 4	90%	**100%**
MCA & DoLS (Advanced)	90%	**66%***
Prevent (Basic Awareness)	90%	**93%**
Prevent (WRAP)	70%	**91%**

**due to the Trust commencing initial training for this programme in 2015 there is now a drop off in compliance, which will be managed with staff release and a training plan. However the Trust is awaiting the publication of the Intercollegiate Document for Adults before it completes the plan as this may impact on the Training Needs Analysis.*

Safeguarding Children

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

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

Following on from the Children & Social Work Act (2017) receiving Royal Assent in 2017, Working Together to Safeguard Children has been revised to reflect the legislative changes within the Act.

Although outside the reporting period for this report, the revised Working Together was published in July 2018 and all necessary policy and procedure updates for Liverpool Women's are being progressed to reflect the changes.

It is anticipated that the new guidance, due to be published in July 2018, will set out the changes needed to support the new system of multi-agency safeguarding arrangements established by the Children and Social Work Act (2017).

Changes to the new guidance are anticipated to be:

✓ <u>Multi-agency safeguarding arrangements</u>

Local Safeguarding Children Boards (LSCBs) will be replaced by "safeguarding partners"

- Under the new legislation, three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) must make arrangements to work together with relevant agencies (as they consider appropriate) to safeguard and protect the welfare of children in the area
- The 3 safeguarding partners should agree on ways to co-ordinate their safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents
- To fulfil this role, the three safeguarding partners must set out how they will work together and with any relevant agencies

- All 3 safeguarding partners have equal and joint responsibility for local safeguarding arrangements

Relevant agencies are those organisations and agencies whose involvement the safeguarding partners consider is required to safeguard and promote the welfare of local children. For local arrangements to be effective, they should engage organisations and agencies that can work in a collaborative way to provide targeted support to children and families as appropriate. The safeguarding partners must set out in their published arrangements which organisations and agencies they will be working with to safeguard and promote the welfare of children.

✓ National and Local Safeguarding Reviews

The new Working Together to Safeguard Children (2018) guidance will set out the process for new National and Local Safeguarding Reviews (previously Serious Case Reviews – SCR's) The responsibility for how the system learns the lessons from serious child safeguarding incidents will lie at a national level with the Child Safeguarding Practice Review Panel (the Panel) and at local level with the safeguarding partners; who have strict timeframes to complete a rapid review of cases that could potentially fulfil the criteria for an SCR. A copy of the rapid review should be sent to the Panel who decide on whether it is appropriate to commission a national review of a case or cases.

The Child Safeguarding Practice Review Panel will be responsible for identifying and overseeing the review of serious child safeguarding cases that raise issues that are complex or of national importance.

During this reporting period and whilst awaiting the new guidance, the Safeguarding Team have had direct involvement in three new Serious Case Review's.

The Safeguarding Team regularly review the Safeguarding Training and include the findings from local and national Review's; and to ensure the learning is embedded, the Team deliver a one hour 'lessons learned training session, bi-monthly in conjunction with our Learning and Development Department.

✓ Child Death Reviews

The 2018 'Working Together' guidance replaces the requirement for LSCBs to ensure that child death reviews are undertaken by a Child Death Overview Panel (CDOP) with the requirement for 'Child Death Review Partners' (consisting of local authorities and any clinical commissioning groups for the local area) to make arrangements to review child deaths.

Safe Sleep

In March 2017, the Merseyside Safe Sleep Group completed an audit to assess the compliance with the Safe Sleep pathway and the use of Safe Sleep materials.

The audit results, that were shared with the Local safeguarding Boards, Heads of Midwifery, Nursing, CCG's and Public Health Commissioners, highlighted varying levels of compliance against the Pan Merseyside Safe Sleep Guidance from maternity and community health services.

As a consequence, the LSCB Chair's requested assurances back to the Board's that the findings and any subsequent actions relevant to the partnership have been addressed.

Following the dissemination of the initial results findings, LWFT have completed a further audit and added it to the Trust's Annual Audit Plan moving forward. Once compiled, these results and evidence of any changes will be communicated with our commissioners and Safeguarding Boards via LWFT's HSB and CQPG.

Child Sexual Exploitation (CSE)

High profile cases in the UK (Rochdale, Rotherham, Oxfordshire and Wirral) have highlighted health services significant contribution in the identification and response to cases of sexual exploitation. As such, NHS England has recognised CSE as a national priority for all health staff and agencies.

The updated PAN Merseyside Multi-Agency Protocol (2018) seeks to unify a process of recognition, risk assessment, referral and discussion amongst professionals utilising a single process and document set for all. The Protocol aligns with local geographical area arrangements to safeguard children and sets out a clear pathway by which to ensure all organisations unify to provide the best service possible for all children and young people who are at risk of being exploited across Merseyside.

The below nationally agreed definitions are utilised across Merseyside:

<u>Child Sexual Exploitation</u>

Child Sexual Exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity:

(a) In exchange for something the victim needs or wants, and/or
(b) For the financial advantage or increased status of the perpetrator or facilitator

The victim may have been sexually exploited even if the sexual activity appears consensual. Child Sexual Exploitation does not always involve physical contact; it can also occur through the use of technology (Home Office 2017).

Child Criminal Exploitation

Child Criminal Exploitation occurs where an individual or group takes advantage of a person under the age of 18 and may coerce, manipulate or deceive a child or young person under that age into any activity:

(a) In exchange for something the victim needs or wants
and/or
(b) For the financial advantage or increased status of the perpetrator or facilitator
and/or
(c) Through violence or the threat of violence

The victim may be exploited even if the activity appears consensual (i.e. moving drugs or the proceeds of drugs from one place to another).
Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology (Home Office 2018).

County Lines

County lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas (within the UK), using dedicated mobile phone lines or other form of “deal line”. They are likely to exploit children and vulnerable adults to move (and store) the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons (Home Office 2018).

Each Local Safeguarding Children Board provides scrutiny, oversight and quality assurance of the local Child Exploitation processes. The Strategic Governance of the wider multi-agency response to Child Exploitation across Merseyside is undertaken by the Regional Strategic Multi-Agency Child Exploitation (Regional MACE) Group.

The Pan Merseyside Child Sexual Exploitation Multi-Agency Strategy also sets out agency responsibilities in the identification of young people who use our service. To ensure staff are aware of how to recognise young people potentially at risk and know how to refer them as appropriate moving forward, the following has been put in place:

- All LWFT staff receive CSE Training in their Mandatory Level 1and 2 Training and Safeguarding Children Level 3

- Staff in high risk areas such as GED and Bedford will have a 'checklist' to help them identify vulnerabilities and behaviours which might be indicative that a young person might be at risk of CSE
- Following a Joint Targeted Area Inspection (JTAI) in Liverpool, all CSE referrals are discussed in the Multi Agency Safeguarding Hub (MASH) and then shared with all Trust's in order to undertake any additional information requests and 'flag' on Meditech.

Building on the foundation work already completed by the Safeguarding Team, identification and responding to CSE/CCE will remain a priority in the coming 12 months.

Voice of the Child

The failure to listen to children and ensure their views are taken into account in child protection cases has been highlighted in many Serious Case Review (SCR) findings. However, actively involving children is difficult to embed in a provider organisation which predominantly delivers healthcare to adults.

LWFT do however, provide care to young adults under 18 years of age, especially in an unplanned and specialist care setting and we will therefore be required to work in conjunction with our external partners to address this risk.

In response to a Practice Learning Review, in November 2017, the LSCB developed the 'Voice of the Child; practice guidance for health professionals'. This has been shared with commissioned health services through the LSCB Health sub group and is to support health professionals in capturing the voice of the child; which is then in turn disseminated to our staff through training.

As part of the 0-25 Special Educational Needs & Disability (SEND) improvement journey our local Commissioners have established a Health Economy SEND Strategic Working Group. The Trust Associate Director for Nursing and Midwifery for Safeguarding is the strategic lead for SEND from within our organisation and the Specialist Nurse/Midwife for Safeguarding Children attends the meetings to progress this work, which takes into account the voice of the child.

Looked After Children (LAC)

A 'Looked after Child' (LAC) is a child who is accommodated by the local authority; a child who may be the subject of an Interim Care Order, full Care Order or Emergency

Protection Order; or a child who is remanded by a court into local authority accommodation or Youth Detention Accommodation.

In addition where a child is placed for Adoption or the local authority is authorised to place a child for adoption - either through the making of a Placement Order or the giving of Parental Consent to Adoptive Placement - the child remains a LAC until a final order has been granted by the courts. LAC may be placed with parents, foster carers (including relatives and friends), in Children's Homes, in Secure Accommodation or with prospective adopters.

Healthcare services have a responsibility to keep children safe and as a LAC may access the Trust via unplanned care, staff are asked to notify the Safeguarding Team of this young person's admission or attendance in order for the information to be shared with the relevant Social Worker and Local Authority.

NHS investigation into matters relating to Child Sexual Abuse (Lampard Review)

In October 2012 the Secretary of State for Health the Lampard Review; which was independent oversight of the investigations at three NHS hospitals (Leeds General Infirmary, Stoke Mandeville and Broadmoor) and the Department of Health into the associations that the late Sir Jimmy Savile OBE, (Savile), had with those hospitals and the department; and allegations that Savile committed sexual abuses on the hospitals' premises.

The review led to a 'lessons learned' report, drawing on the findings from all published investigations and emerging themes. This led to the development of 14 recommendations for the NHS, the Department of Health and wider government.

Although there are some organisations that are still yet to provide assurance against all 14 of the recommendations; Liverpool Women's have provided full assurance around compliance. This has been reported to NHS England Cheshire and Merseyside Quality Surveillance Group, via our Commissioners.

Following the review, in 2015, the Independent Inquiry into Child Sexual Abuse (IICSA) was established in order to investigate organisations and institutions that have failed to protect children from sexual abuse.

In order to understand the past to help protect children now and in the future, the 'Truth Project' was set up for victims and survivors of child sexual abuse to share their experiences in a supportive and confidential setting. By sharing their experiences, victims and survivors are able to provide an important contribution to

the work of the Inquiry and their experiences will influence future recommendations to ensure children are protected.

This year, Liverpool Women's supported the Inquiry in terms of increasing the awareness of the Truth Project, the use of screensavers, posters and display cards in our clinical areas.

Child Protection Information Sharing (CP-IS)

CP-IS connects Local Authority Children's Social Care systems with those used by NHS unscheduled care settings, such as A&E, Walk-in Centres, and Maternity Units. It ensures that health care professionals are notified when a child or unborn baby with a child protection plan (CPP) or looked after child status (LAC) is treated at an unscheduled care setting. CP-IS is a secure system with clear rules governing the access and only authorised staff involved in the care of a child are able to access the information.

Social care teams are alerted automatically when a child in their care attends an unscheduled care setting every time the system is accessed.

Providing instant access to this information means vulnerable children can be identified wherever they are cared for in England.

Sefton and Knowsley Local Authorities are currently utilising the system within their unscheduled care settings, however Liverpool Local Authority is currently awaiting go live.

Key Principles:

- The CP-IS is for use in an unscheduled setting, i.e. not booked with our services and as such they may have no maternal notes.
- The expectant mother's details are checked on the system via smartcard access directly to the summary care record via NHS Spine Portal.
- The unborn is linked directly to the mothers NHS number and therefore only maternity staff with the correct access (RBAC) codes can see maternal records.
- The information we receive from searches shows live and current data.
- The details of the plan will not be visible – normal safeguarding process will be followed if attendance is of a concern.
- The name and the title of staff requesting information (this can be defaulted for whole trust e.g. Safeguarding Team) is recorded and becomes part of an attendance record that is visible to any other consequent departments that access the child records.

- The staff can see a record if mothers are accessing multiple organisations.

The criteria for CP-IS is to access the system for any child who accesses LWFT Emergency Department and any unbooked patient pregnancies attendances. LWFT fully integrated with CP-IS on 15th January 2018 and since that date has noted the following benefits:-

- The risk of missing a child known to a Local Authority (nationwide) is reduced
- With instant access to child protection information, communication with the appropriate social worker can take place quickly leading to a better outcome for the child.

Safeguarding Adults

Over the last 3 years significant investment and progress has been made to promote the Safeguarding Adults Agenda across the Trust. The Safeguarding Team have continued to build upon the work already accomplished, endeavouring to increase the identification of potential abuse and subsequent referrals as well as continued to work collaboratively with external partners in safeguarding those adults most vulnerable to abuse.

The specialist nature of the Trust combined with the limited numbers of adults with additional needs is reflected in the low referral rates to Social Care in respect to allegations of abuse. However, there is clear evidence that once identified; the robust processes in place ensure that the Trust is compliant with multiagency processes to protect those adults at risk of abuse.

The focus within the last 12 months has been to review the processes relevant to the Safeguarding Adult agenda that were originally developed in 2015-16. Included within this review has been a review of all relevant policies and procedures pertinent to Safeguarding Adults in a hospital setting to ensure the principles of the Care Act (2014) continue to be embedded in practice, thus improving collaborative working within the multi-agency Adult setting.

In preparation for the publication of the Adult Safeguarding: Roles and Competencies for Health Care Staff (due to be published in August 2018) all existing training packages are currently being reviewed. The new guidance is expected to provide clarity in respect to the competencies required in order to support individuals to receive personalised and culturally sensitive safeguarding and will set out the minimum training requirements along with education and training principles.

In accordance with guidance, further development of our existing training, will be a priority for the Team in the coming 12 months.

Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009) (MCA & DoLS)

Following an internal, in-depth review in 2015, concerns were identified in respect to compliance with the Act. In response, to improve compliance with the principles of the Act, the following recommendations were made:

- Training for all doctors and delegated professionals in the application of the Mental Capacity Act (2005) in respect to the Acute care setting
- Review of documentation adding appropriate prompts to facilitate compliance
- Processes to access expert advice and support to be embedded

This year sees the second year in succession where compliance, demonstrated through audit, has been evidenced, providing the relevant assurance required in respect to embedding the Act in practice.

Although it can be seen that our clinicians have a clear understanding of the Act and comply with the principles appropriately; the Safeguarding Team continue to provide support in respect to complex and challenging cases. Ultimately this reduces the need to access legal advice and maintains the safe provision of care.

In respect to Mental Capacity (Amendment) Bill (2017-19), the Trust has contributed to the reform of the Deprivation of Liberty Safeguards (DoLS) legislation. The Bill follows on from the Law Commission's recommendations published in 2017 and proposes to abolish the Deprivation of Liberty Safeguards, by deleting Mental Capacity Act 2005 (MCA) Schedule A1 and 1A, and adding a new Schedule AA1, commonly referred to as the 'Liberty Protection Safeguards'.

Key features of the Bill include hospitals becoming responsible for authorising their own DoLS, as opposed to Local Authorities currently providing authorisation; and the introduction of Approved Mental Capacity Professionals. They will bring independent scrutiny to cases where the "person being cared for does not wish to reside in hospital or to receive care", i.e. effectively only in cases of "objection" by the patient.

Whilst the Bill is not expected to be passed before 2019-20 and enacted before 2021, Safeguarding continues to monitor the progress of the Bill through parliament in readiness for any required changes to be implemented.

Learning Disabilities & Dementia

This year has seen the Trust continue to work in collaboration with external health providers and service users to improve the experiences of patients with additional needs. This has included discussions with relatives and carers through the delivery of the combined learning disability, dementia and autism strategy developed in 2015-16.

The Trust have embedded the processes for delivering key aspects of the Department of Health's 'Transforming Care Programme' for patients with a learning disability; including ensuring reasonable adjustments are made to improve access to health care and supporting patients, their relatives and carers with support and feedback through our programme, 'Ask Listen Do'.

This year, via its membership of the Learning Disabilities Acute Care Network, the Trust has contributed to the development of a standardised basic awareness training

package. Developed in collaboration with Mencap, the training has been designed specifically for use in all Acute Trust providers in Merseyside and in the coming 12 months will be embedded in the Trust Safeguarding Training Strategy.

Compared to the 2016-17 in respect to identifying patients who may benefit from having Reasonable Adjustments made, completing Reasonable Adjustment Risk Assessments and gaining patient/carer feedback; this year's audit has shown a reduction in compliance. In response and in collaboration with key members of clinical staff, the Named Doctor for Safeguarding Adults, the Safeguarding Team have started to review the current processes in order to identify any contributory factors. Initial results have shown that we will need to provide some additional, bespoke, training for pre-operative staff promoting the Reasonable Adjustment process and the inherent benefits the process has to patient care.

Domestic Abuse

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

Although not limited to, it can encompass:

- Psychological, physical, sexual, financial and emotional abuse

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

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

The impact of domestic abuse to health and in particular women has been widely researched and documented:

- Women are much more likely than men to be the victims of high-risk or severe domestic abuse; with the incidence becoming even higher in pregnancy with around 30% of abuse beginning during pregnancy, while 40–60% of women already experiencing abuse continue to be abused

- The NHS spends more time dealing with the impact of violence against women and children than almost any other agency and is often the first point of contact for women who have experienced violence

- Each year, more than 100,000 British adults are at high and imminent risk of being murdered or seriously injured as a result of domestic abuse; with over 130,000 children living in these homes

- The cost of domestic abuse to health services has been calculated at £1.73 billion (with mental health costs estimated at an additional £176 million) so there is a pressing need to find cost effective ways of supporting victims

In 2016, ‘SafeLives’ (Home Office Charity previously known as CAADA) commissioned a piece of research looking at the response required to disclosures of domestic abuse in a healthy setting; and in particular around the impact of co-locating Independent Domestic Violence Advocate (IDVA) services in hospitals.

The report recommended that the health response to domestic abuse needed to be strengthened and outlined that if domestic abuse disclosures were to be responded to more effectively and timely when identified in hospital, the wider and more detrimental costs could be minimised and harm to victims and children potentially avoided. By ensuring stronger links between the health sector and domestic abuse support services; and by co-locating IDVA services within a hospital setting (specifically A&E and Maternity Services), health and wellbeing outcomes significantly improved for victims of domestic abuse; and that of their associated family.

Given that Liverpool Women's specialise and is recognised for having the most outstanding expertise and experience in the health of women and their babies, it’s appropriate that our response to the issue is in line with national guidance and evidence based research.

Therefore, this year, we completed a review the Trusts domestic abuse internal processes and in particular, response to the issue. As such, we have successfully recruited a Children’s Social Worker into the Safeguarding Team, who is also a qualified IDVA. This role will ensure the appropriate identification, referrals and support for our patients who disclose domestic abuse.

In line with our Trust vision and values, to be a recognised leader of healthcare for women, babies and their families, dedicated to the delivery of excellent healthcare and safe services, in a safe environment; this is an extremely positive appointment to the Team.

Multi-Agency Risk Assessment Conference’s (MARAC)

The Trust continues to work in collaboration with our external statutory partners by referring and attendance when required at the MARAC. This enables maximum information sharing between relevant agencies within an agreed protocol. It allows for the agencies to identify those most at risk from violence and abuse and thereafter jointly construct a management plan to provide a professional, co-ordinated approach to all reported incidents of domestic abuse.

All Trusts are required to provide health information relevant to the cases being discussed for all MARAC meetings and attend the meetings where victims who are

referred by the Trust, are discussed. Throughout this reporting period LWFT have continued to provide all appropriate health information to Liverpool North and South, Sefton and Knowsley MARAC's and attend as required.

In this reporting period, there were 903 referrals for domestic abuse into the Safeguarding Team, which is an increase of 228 cases compared to 2016/17. We envisage with the specialist role and support within the Team, this will increase further in the coming 12 months.

Domestic Homicide Reviews (DHRs)

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

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

LWFT have been involved in the DHR process since they were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004), in April 2011.

In this reporting period, the Trust has completed of two DHR chronology's and in both cases there were no poor practice points identified for the Trust.

Once again, the Trust was commended for our support for victims of domestic abuse. The processes we used and our response and management of cases known to us were used in LSCB training as evidence of 'best practice'.

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

The 'Protecting Vulnerable People Agenda' remains a priority for Liverpool. Initial scoping work undertaken by the Office of the Police and Crime Commissioner and Police, looking at the Strategic Governance required, led to the formation of the Pan Merseyside Harmful Practices Group. As well as developing an agreed Pan-Merseyside Policy, this group leads on raising awareness among professionals and practitioners of harmful practice such as Forced Marriage, Honour Based Violence and Female Genital Mutilation.

The group meet on a quarterly basis to look at the key work streams, which include:

- Monitoring whether partners are undertaking FGM mandatory reporting, ensuring statutory compliance

- Developing a set of commissioning standards (KPI's) for FGM which will be implemented in 2018-19

- Health provider readiness for FGM – IS (Indication System)

The Associate Director of Nursing and Midwifery for Safeguarding sits on this Group representing Liverpool Women's.

This year, Liverpool Women's have been approached by NHS Digital to pilot their new Programme, FGM – IS. The Safeguarding Team have now met with the Programme Leads and are currently working on the pilot, prior to the roll out for the other Provider Trusts 2018-19.

Human Trafficking / Modern Slavery

In recent years, the Safeguarding Team have had involvement with an increasing number of cases involving modern slavery and human trafficking; also known as Serious & Organised Crime threats.

In such cases, the Trust has a duty to support but also refer any concerns for the unborn into the Local Authority. However, as many of these cases are referred to the Home Office for specialist support, there was often limited information available regarding the outcomes to our concerns.

To be better able to identify and understand the potential issues and any operational opportunities for working together to tackle it, in 2016, the Associate Director of Safeguarding met with the Assistant Chief Constable (ACC) for Merseyside Police who leads the North West Regional Organised Crime Unit (NWROCU) also known as 'Titan'. Titan has responsibility for a wide range of issues, of which includes Modern Slavery, Child Sexual Exploitation and Organised Immigration Crime.

Following on from our initial work with Merseyside Police, we now have a more robust process in place whereby any patient who has been identified as potentially being at risk of being/has been trafficked is seen by Safeguarding. This also applies

to un-booked pregnancies particularly young Eastern European females with whom there are concerns regarding their stories or relatives/visitors.

If found that the patient is potentially the subject of trafficking a referral is now made to Merseyside Police Human Trafficking Team along with a referral to the relevant local authority for children and/or adults if appropriate.

A key benefit of this joint working with Merseyside Police has been the 'real time' access to operational data and intelligence. It has enabled clearer identification of individuals and groups involved, allowing for opportunities to disrupt, prevent and prosecute (for Police) those responsible; and ultimately for LWFT, an ability to successfully safeguard vulnerable victims as appropriate, with evidenced outcomes. It has also enabled the Safeguarding Team to enhance their knowledge base regarding trafficked cases and serious and organised crime threats, which has sometimes led to the appropriate challenge around Local Authority decision making; thus ensuring advocacy for this vulnerable cohort of women.

On average the Safeguarding Team receive 1 or 2 referrals per week for women who disclose / or it is suspected that they have been trafficked.

Safeguarding Supervision

Safeguarding Supervision continues to be provided for all Trust staff that hold a child protection caseload. Supervision provides a framework for examining a case from different perspectives and enables staff members to deal with the stresses inherent in working with vulnerable children, young people and adults at risk and their families. In a safe environment, it allows staff to explore their own role and responsibilities in relation to the families they are working with and facilitates good quality, innovative and reflective practice.

The provision of Safeguarding Supervision ensures that the Trust is discharging its statutory duties and responsibilities as a safeguarding agency; providing a high quality service to those deemed to be at risk of abuse and forges a line of accountability between the individual, the employee and the organisation.

Following a review of the Trusts Safeguarding Supervision policy in 2015, the Trust sourced a training course from the National Society for the Prevention of Cruelty to Children (NSPCC) to allow key staff to provide Safeguarding Supervision. However, due to the increase numbers in referrals and further scrutiny regarding the provision of supervision, the organisation will need to increase the amount of staff they have trained to provide Safeguarding Supervision. NHS England have commissioned two training courses for later this year, which we have identified a cohort of staff to attend.

Safeguarding Service Review

Following the initial Safeguarding Service review completed in 2014, the consistent, responsive approach of the Trust's Hospital Executive Board, has supported the continual review of the structure and skill mix within the Team; thus ensuring LWFT are able to meet the service demands and remain compliant with their statutory duty.

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

This year, as in previous years, the Team were commissioned to complete a Safeguarding Peer Review for local Provider Trust in preparation for their Themed CQC Inspection. The review led onto the provision of key staff supporting Aintree University Hospital NHS Foundation Trust in the development of a Strategy and accompanying Improvement Plan for their service.

This work has now been completed and the initial foundations combining both child and adult Safeguarding processes have been successfully established. The newly recruited Aintree Team have begun to build on their knowledge and competencies in Safeguarding, enabling them to deliver the developed Strategy and Improvement Plan.

In order to promote and enhance their learning and ensure resilience between the roles which will enable clinical capacity and relevant core and specialist clinical competence within the service; under the terms of a Service Level Agreement, LWFT will continue to provide Aintree with the Named Nurse for Safeguarding Adults / Lead for MCA & DoLS / LD & Dementia (0.6 WTE).

Key Objective for 2018-19

2017/18 has again been a year of significant activity and scrutiny. Throughout this time, the Trust has successfully demonstrated that robust mechanisms remain in place to safeguard adults, young people and children from abuse.

However, as approach's to Safeguarding continually evolve and the complexity of decision making increases around newly recognised forms of harm and abuse, the current structures and process will be required to continue to develop in response.

Therefore, aside from further embedding of existing overall process, the following key areas / objectives for improvement have been identified in the priorities for 2018/19:

1. Fully implement Safeguarding Adults Intercollegiate (August 2018) guidance in respect to levels of training.

2. Fully implement Working Together to Safeguard Children (August 2018) guidance ensuring the changes are reflected in Safeguarding policy, protocol and training.

3. Develop and implement advanced training sessions for senior medical staff in respect to managing complex cases involving the Mental Capacity Act.

4. Review the Trust Cognitive Impairment strategy and the supporting policies and procedures in accordance with recently released national guidance.

5. Liaise further with EPR to ensure that all safeguarding processes currently in place can be replicated robustly within the new EPR system to enable greater confidential sharing of safeguarding information across the workforce.

6. Set up enhanced data-sets for specific Trust safeguarding agendas to assist strategic direction for resource allocation and improve the ability of external partners to present an accurate picture of the local safeguarding landscape

7. Further develop and strengthen our domestic abuse processes in particular responses to disclosures, collaboration with external partners and implementation of advanced training sessions for senior staff in respect to managing complex cases and risk assessments.

Agenda Item	2019/012(2)

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	Care Quality Commission (CQC) Review of Health Services for Looked After Children and Safeguarding in Sefton – implications for Liverpool Women's
DATE OF MEETING:	Friday, 01 February 2019
ACTION REQUIRED	**For Noting**
EXECUTIVE DIRECTOR:	Caron Lappin, Director of Nursing and Midwifery
AUTHOR(S):	Mandy McDonough, Associate Director of Nursing and Midwifery for Safeguarding
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 next steps :*** ***In response to the recommendations identified, Liverpool Women's should now discuss how best to prepare working together to support other Health providers to improve Safeguarding processes and children's experiences of health services.*** ***As part of the discussions around joint working and supporting neighbouring Trusts, Liverpool Women's will need to take into account any capacity issues, the resources available and their current strategic and operational safeguarding responsibilities.***			
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.*		

Care Quality Commission (CQC) Review of Health Services for Looked After Children and Safeguarding in Sefton

Implications for Liverpool Women's NHS Foundation Trust

1. Situation

This report summarises the findings of the recent Care Quality Commission (CQC) Review of health services for Looked after Children and Safeguarding in the Sefton area.

The review focused on the experiences and outcomes for children within the geographical boundaries of the Sefton Local Authority area and reported on the performance of health providers serving the area including Sefton's Clinical Commissioning Group (CCG) and Local Area Teams (LATs).

Southport and Ormskirk NHS Trust, Alder Hey Children's NHS Foundation Trust, North West Boroughs Healthcare NHS Foundation Trust, Mersey Care NHS Foundation Trust and Addaction were part of the review; and although a commissioned service of Liverpool CCG, Liverpool Women's NHS Foundation Trust Safeguarding Team were also included.

2. Background

The review was conducted under Section 48 of the Health and Social Care Act (2008) which permits the CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

The review looked at the:

- Role of healthcare providers and commissioners
- Role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews
- Contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

In addition checks were made as to whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act (2004). This includes the statutory guidance, Working Together to Safeguard Children (2018).

A range of methods were used to gather information both during and before the visit including document reviews, interviews, focus groups and site visits.

A number of individual cases were tracked where there had been safeguarding concerns about children. This included some cases where children were referred to social care, cases where children and families were not referred and cases that were assessed as needing early help and received it from health services. The experiences of looked after children were

also considered to explore the effectiveness of health services in promoting their well-being.

In total, the experiences of 140 children and young people were considered, along with the findings in relation to children and young people of previous CQC inspections of all five of the provider NHS Trusts identified to participate in the review.

3. Assessment

The Review considered children's experiences of health services in relation to early help, safeguarding, child protection and looked after services, as well as reviewing the governance and assurance processes within the areas inspected.

In regard to those areas, the findings and feedback for Liverpool Women's was as follows:

Early Help

- Expectant women attending Liverpool Women's Hospital for their maternity care, benefitted from effective risk assessments, including the assessment of their social vulnerability. In all case records reviewed by the inspectors, where it had been possible to identify the father of the unborn child, this had been recorded on the maternity systems

- The identification of additional vulnerabilities such as learning difficulties, physical or mental ill-health were also recorded at booking, enabling midwives and other clinicians providing care throughout pregnancy to be fully informed of any identified risks as early as possible

Children in need

- Pregnant women accessing maternity services from Liverpool Women's Hospital benefited from joint clinics run by specialist midwives and obstetricians when perinatal mental health concerns had been identified

- Inspectors saw evidence that maternal mood is considered, and individualised care plans are developed in conjunction with the woman, which are flexible and woman centred and where appropriate, results in a referral to Mersey Care NHS Foundation Trust's adult mental health service. This ensures that women receive early intervention and support to improve their mental health and well-being and increase their ability to parent

Child Protection

- In respect to Liverpool Women's Hospital Trust there was evidence of clear planning to protect the unborn child. Effective systems were found to be in place to ensure that referrals to children's social care are routinely followed up

- Unborn and new-born babies are safeguarded through the appropriate sharing and recording of important information pertaining to risk. Tracking systems and information sharing forms to ensure that women who are mobile across Merseyside and who may present at any of the areas' maternity units are shared with neighbouring hospitals

- In order to protect the newly born infant from being taken from the Liverpool Women's Hospital; effective, regular abduction drills take place so that staff are aware of what to do if a baby is abducted. It is a feature of the building and baby tagging systems that the whole area can be locked down to prevent a baby being taken from the premises

- Robust safeguarding arrangements were evident and found to be in place for women who book late or arrive at Liverpool Women's Hospital in labour to ensure that checks are undertaken with the woman's home local authority children's social care teams

- The Associate Director of Nursing and Midwifery for Safeguarding, who is also the Named Midwife, had worked closely with Merseyside Police on a project to identify expectant women who are unknown to local services and have come from abroad. This has enabled early identification of possible CSE and trafficking cases and has resulted in an increase in referrals to children's social care and joint targeted input from Merseyside Police. The project has been evaluated well and as this has been successful, will be used as a benchmark for other Maternity Services/Police Forces

- One of the safeguarding practitioner 's within the Safeguarding Team at Liverpool Women's Hospital has a joint role as an independent domestic abuse advocate (IDVA); to support women who experience, or are identified as at risk of domestic violence and abuse. This supports a strong multi-agency approach to safeguarding children and is consistent with best practice and legislative requirements

Governance

- Appropriate use of the CPIS system are made when women arrive un-booked / in labour at Liverpool Women's Hospital or in an unscheduled care setting. This has resulted in increased referrals to children's social care and enabled appropriate plans being put in place to protect the unborn child

- Family composition is not consistently documented in health records across services in Sefton, including primary care, which can hinder a 'Think Family' approach. For example, the electronic systems are not all conducive to recording the details of fathers or other adults living in the family home. However, the quality of maternity record keeping regarding linked children and adults was good in Liverpool Women's Hospital

Supervision

- Midwives working for the Liverpool Women's Hospital access quarterly supervision. Inspectors saw evidence of up to date supervision records for the Enhanced Midwifery Team which were reflective and not limited to those expectant women where there was an unborn child protection plan, or where it was indicated that child in need arrangements would be needed

Recommendations within the report

In total, 48 recommendations have been identified following the review. The following are recommendations specifically identifying actions involving Liverpool Women's NHS Foundation Trust.

NHS South Sefton CCG and NHS Sefton and Formby CCG, Southport and Ormskirk NHS Trust, Liverpool Women's NHS Foundation Trust and North West Boroughs Healthcare NHS Foundation Trust should:

- Work together to ensure that all practitioners working with pregnant women are fully cognisant in current LSCB processes for pre-birth assessments

Southport and Ormskirk NHS Trust, Liverpool Women's NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust, North West Boroughs Healthcare NHS Foundation Trust, Mersey Care NHS Foundation Trust and Addaction should:

- Implement a proactive process of follow-up to ensure that child protection conference minutes are shared with health practitioners and routinely stored securely on service users' records

- Work together to implement a rolling programme of training and audit which will embed and regularly evaluate, the effective capture of the voice of the child in daily practice, including the unborn child, through improved record-keeping

- Work together to implement a rolling programme of training for practitioners on the analysis and articulation of risk and its impact on children and young people. This should include clear evaluation of the impact of the training on practice through regular audit

Liverpool Women's NHS Foundation Trust and Southport and Ormskirk NHS Trust should:

- Implement a process to effectively monitor midwives' compliance with level three child safeguarding training as per RCPCH Intercollegiate Document (2014). This is training completed as per LSCB guidance, provided externally to the Trust

4. Recommendation

In response to the recommendations identified, Liverpool Women's should now discuss how best to prepare working together to support other Health providers to improve Safeguarding processes and children's experiences of health services.

As part of the discussions around joint working and supporting neighbouring Trusts, Liverpool Women's will need to take into account any capacity issues, the resources available and their current strategic and operational safeguarding responsibilities.

Agenda Item	2019/013

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Listening Events: A Summary of the First Year**
DATE OF MEETING:	Friday, 01 February 2019
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Michelle Turner, Director of Workforce and Marketing
AUTHOR(S):	Jean Annan, Head of OD and Rachel London, Head of Operational HR
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** **1.** To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☒ **2.** To be ambitious and ***efficient*** and make the best use of available resource ☒ **3.** To deliver ***safe*** services ☒ **4.** To participate in high quality research and to deliver the most ***effective*** Outcomes ☒ **5.** To deliver the best possible ***experience*** for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust……* ☒ ***2.*** *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:-….)***	Receive and consider the summary of the Listening Events, including the Feedback from the November 18 Listening Event. Commit to continued regular attendance at Listening Events Provide challenge into the organisation and gain assurance that the feedback from staff is being acted upon	
PREVIOUSLY CONSIDERED BY:	**Committee name**	***Choose an item.*** Or type here if not on list: ***Click here to enter text.***
	Date of meeting	***Click here to enter a date.***

Executive Summary

Board Listening Events commenced in July 2017 as part of the Trust response to feedback in the Annual Staff Survey and a desire to strengthen the relationship between staff and senior managers. The events use an appreciative enquiry approach to explore issues that were impacting on Staff Engagement and at the same time to provide opportunity for staff and senior managers to communicate openly, to confront barriers raised through silo working and to identify collectively potential solutions. This paper provides a summary of the four events held so far.

In broad terms, the feedback from all 4 events consistently reported staff:

- Welcoming the opportunity to speak freely away from the workplace with very senior leaders
- Valuing time spent with colleagues from other areas/disciplines and realised the benefit of tackling silo working
- Optimising the opportunity to develop an understanding of different demands on their colleagues
- Suggesting PDRs should be more meaningful and helpful, with recognition for good work done and support to learn and improve
- Valuing the opportunity to speak with Senior Managers, and wanting them to be more accessible including the chance to speak with them in their own areas
- Wanting the values and behaviours of the Trust truly modelled by all at every level, and that action be taken where that wasn't the case – they talked about people being kinder, saying thank you and demonstrating appreciation
- Desiring constructive, positive and widely shared learning from incidents
- Articulating that patient experience is intrinsically linked with staff experience
- Requesting access to a wide range of Health and Wellbeing activities, closer to their place of work

Outcomes of the individual events inform actions in their respective work streams and "you said, we did" progress updates are provided at each follow up listening event. In the Loop, the Health and Wellbeing Newsletter and Staff Track are utilised to provide feedback on issues raised and actions taken to the wider workforce. Progress and effectiveness continue to be monitored through the Putting People First Committee as part of the ongoing delivery of the People Strategy.

Board are asked to

- Receive and consider the summary of the Listening Events
- Commit to continued regular attendance at Listening Events
- Provide challenge into the organisation and gain assurance that the feedback from staff is being acted upon

Report

1. Background

The aim of the Listening Events was to bring together members of staff from across the Trust to reflect on issues raised via staff survey and to explore ways to share learning and improve staff experience, whilst at the same time giving them the opportunity to spend time with Directors talking openly about the issues that impact on staff engagement.

The objectives of the Listening Events included communicating acrossservices and teams, creating shared direction and momentum for action, generating new insights, building a sense of community and trust through open discussion and sharing, and positive engagement with staff and Trust Directors.

Using the approach of appreciative enquiry, this encouraged staff to celebrate what worked well in their areas, thus passing on valuable experience and insight, and celebrating excellence with colleagues and senior managers. It encouraged generation of new ideas and suggestions, and potential to explore new possibilities. It also allowed for a positive experience for all staff, noted in the high energy levels in the room throughout all of the events.

Following the positive reception from the first event and the feedback that staff would welcome further opportunities for open discussion, the Board committed to supporting Listening Events on a Quarterly basis. This has enabled gathering of intelligence from a cross section of staff when considering how to progress some of our critical work streams, fostering inclusion and combatting silo working. The events are now regarded as a feature of engagement in the Trust.

The four events so far have provided an opportunity to include staff in addressing key areas where staff indicated that the Trust performed less well the other Specialist Trust.

- Event 1 focused on Trust Values and gave staff and senior managers the opportunity to discuss what it was like to work at LWH and what could be improved.
- Event 2 explored how Health and Wellbeing of staff could be improved
- Event 3 provided an opportunity to engage staff with the Fair and Just Culture project, providing an understanding of what staff understood by the term and how they felt that the culture could incorporate the principles
- Event 4 sought to understand why more staff hadn't recommended the Trust as a place to have care on the Annual Staff Survey (79% compared to 89% in Specialist Trusts)

Events are well attended; however a greater presence from the Medical staff and more clinical staff would provide a more representative group. Clinical pressures are usually cited as the reason for this. Regular events do; however allow over the course of a year different people to attend and the evets are normally a mixture of some who have attended previously and new attendees.

2. **Overview and Outcomes from Listening Event**

Although the themes from the Listening Events have differed and provided information for diverse work streams, they demonstrate a common thread that relates to staff engagement which is fundamental to achieving any aspect of Trust business and most importantly to excellent patient care. As noted in all previous papers, the common themes emerging were:

- The opportunity to speak freely away from the workplace with very senior leaders
- Value of time spent with colleagues from other areas/disciplines and realised the benefit of tackling silo working
- Opportunity to develop an understanding of different demands on their colleagues
- PDRs to be more meaningful and helpful, with recognition for good work done and support to learn and improve
- Opportunity to speak with Senior Managers, and wanting them to be more accessible including the chance to speak with them in their own areas
- They wanted the values and behaviours of the Trust truly modelled by all at every level, and that action be taken where that wasn't the case – they talked about people being kinder, saying thank you and demonstrating appreciation
- Constructive, positive and widely shared learning from incidents
- Patient experience is intrinsically linked with staff experience
- Access to Health and Wellbeing activities

Key Themes and Progress

Theme	Action	Outcomes
Staff welcomed the opportunity to speak freely away from the workplace with very senior leaders	The Trust committed to host Listening Events on a quarterly basis	Events continue to be well attended and evaluate very well. Commitment by the Board is welcome and valuable sharing of information continues
Value of time spent with colleagues from other areas/disciplines and realised the benefit of tackling silo working	Managers are asked to promote the opportunity for shadowing and information sharing meetings Managers are encouraged to release staff to attend listening events where possible An informal "coffee buddy" scheme is available to help people meet colleagues from other areas	The leadership programmes promotes system thinking and working practices and PDR workshops discuss opportunities for staff to learn from each other Regular and frequent reminders are sent to senior managers regarding the dates of Listening Events
Opportunity to develop an understanding of different demands on their colleagues	Continue to develop Listening Events as forum for sharing practice and use the opportunity to develop solutions and share good practice Systems Thinking workshop designed, and related to examples in Listening Events Inclusive leadership programme	Sharing good practice and developing ideas captured in feedback and used in work streams Workshop evaluates well and some staff have worked in "partner" areas to understand issues better (eg Theatres and the wards to understand and resolve patient flow problems) Multidisciplinary nature of workshops evaluates well and staff share experiences and successes and understand other's issues better
PDRs to be more meaningful and helpful, with recognition for good work done and support to learn and improve	PDR paperwork and workshops modified to simplify paperwork include Talent Management and Health and Wellbeing. All staff encouraged to attend Webinar available to support good Talent conversations Six monthly focus groups evaluate workshops and rating of quality of PDR recorded by appraise and appraiser on Front sheet of paperwork	PDR workshops normally full and well evaluated. Increase number of appraises who take responsibility for own PDR Gathering of Talent information and signposting staff and managers to relevant development programmes Future plans to incorporate talent information into Strategic Workforce Group agenda
Opportunity to speak with Senior Managers, and wanting them to be more accessible including the chance to speak with them in	Board presence at all Listening Events	Recognition of continued presence and commitment to Listening Events by Board. Staff using the opportunity to share ideas and directly ask

their own areas	Board members visiting local areas regularly Opportunities for staff to speak directly with senior managers	questions. Opportunity for Board members to share information and views Clear desire for culture change demonstrated through discussions
They wanted the values and behaviours of the Trust truly modelled by all at every level, and that action be taken where that wasn't the case – they talked about people being kinder, saying thank you and demonstrating appreciation	PDR workshops focus on values based conversations Leadership Programme workshops are available to all staff and highlight how they relate to Trust values and highlight the importance of role modelling in Leadership Emphasis on participants understanding own behaviour and its impact on others	Attendance at workshops improving slowly with growing diversity of staff groups. Post workshop evaluation and subsequent feedback including informal conversations demonstrate how delegates are using learning to increase understanding of others and ability to provide leadership. Imminent plans to introduce team interventions with the "Listening to Our People" programme will focus on shared values and team support
Constructive, positive and widely shared learning from incidents	Training in Human factors Communication Skills workshops Regular opportunities for feedback to staff Commitment to a 5 year Fair and Just Culture project	Training completed and cascade trainers now in post A range of communication skills training supports the process behind preventing and learning rom incidents The Fair and Just Culture Programme is beginning to engage with the Trust through Listening Events, individual and group meetings and with training for key staff. Feedback from Listening Event 3 provided insight into staff "readiness for change" and will use evidence of current good practice
Access to Health and Wellbeing activities	Re-establishment of HWB Group A range of physical and mental health interventions provided in response to a survey of staff Application for national Workplace Wellbeing Charter	Although the offer compares well to other Trusts, communication and availability locally have been major issues. A range of communication interventions including verbal, intranet and hard copy continues Plans to introduce HWB for Managers workshop to encourage more local intervention

		HWB group to be supported by more senior management and to contain more clinical staff and divisional decision makers to ensure HWB is recognised as a priority across the Trust.

3. **Feedback from the November 18 Listening Event**

This Listening Event focused on better understanding what contributes be to fewer staff recommending the Trust as a place to work or a place for treatment/care (as reported by the annual staff survey) in comparison to other acute specialist organisations.

It was difficult in practice to differentiate staff views on whether they would recommend as a place to work with would they recommend as a place to have care as the two issues are very closely linked. Many themes raised were common to previous Listening Events. Staff valued the opportunity to speak openly in this forum and appeared confident to express their views in the presence of members of the board. The multidisciplinary format continues to evaluate well.

The key messages were:

- Staff from different departments were often not aware of the work of other departments and welcomed the opportunity to share feedback in this way.
- Most staff present at the event were positive about 'their team', stating that they pull together to help each other
- Staff felt that the Trust had a very good reputation in the community and the fact the Trust receives a low volume of complaints was noted.
- There were lots of good examples of how high quality patient care was being delivered, for example by involving patients in serious case reviews.
- Opportunities for the Trust to shape the future of maternity services in the wider region was discussed as a positive
- The need to celebrate success more at every level, locally and through national awards etc was highlighted.
- Opportunities for personal development varied between different departments, genetic counsellors for example, shared how beneficial they found the process of group supervision and a number of staff had received 'human factors' training. A number of staff recognised there is a need to develop our Band 2/3 staff
- It was suggested that staff need to work more flexibly to respond to patient choice, for example Saturday / evening clinics.
- It was suggested that we need to support new starters more effectively through preceptorship and beyond
- Learning from complaints and incidents rather than blame was a key theme
- Staff wanted health and wellbeing to be 'taken to them'- for example choir rehearsals on clinical departments.

3. Summary

Staff attending the Listening Events engage well and generally contribute in a positive manner. Feedback demonstrates the value people place on the opportunity for open discussions with senior managers and that they feel they have had a chance to speak. People enjoy sharing what they do and having the chance to propose potential solutions. There is a consistent recognition of the contribution and presence of the Board at these events and the success is partly based on this continuing support.

Throughout the four events, regardless of subject similar themes recurred which have been highlighted above. Generally these are based on personal and Trust values, behaviours, recognition and influence. These are all linked to engagement, which directly affects patient experience. Further, the positive effect of giving staff the opportunity to talk to each other increases energy and motivation.

Each of the events has been instrumental in influencing and shaping strategy and interventions and has allowed us to ensure we include staff voice and solutions. In order to maintain this level of engagement, feedback on progress is key to future commitment. Driver diagrams are displayed in all listening events showing continued actions; however this is an area that could be explored more including workshops that have been modified as a result of Listening Event feedback, and Trust wide changes or strategy development through In the Loop. Conversations during the events have also been opportunities to discuss progress so far and to build on this

Continuing support of the Board for Listening Events as the local and wider challenges of the NHS increase will contribute significantly to staff engagement. Providing a forum for staff to demonstrate what they are proud of to senior leaders and tell us what they need to be effective and efficient practitioners demonstrates that the Board takes seriously the views of its staff and their ability to contribute to addressing issues facing the Trust in a significant way.

Listening Events will continue to take the opportunity to develop Trust wide initiatives to address concerns highlighted on Staff Survey, to develop the service, to promote better staff engagement and to ensure the best possible care for our patients and their families. Progress against each of the actions is monitored through Putting People First Committee. The next event is on 22nd February. Events for the following year are awaiting confirmation.

4. Board Actions

Board are asked to

- Receive and 12 month review of Listening Events
- Consider the feedback from the November Listening Event
- Commit to continued regular attendance at Listening Events
- Provide challenge into the organisation and gain assurance that the feedback from staff is being acted upon

Agenda Item	2019/014

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Putting People First Strategy 2019-2024**
DATE OF MEETING:	Friday, 01 February 2019
ACTION REQUIRED	**For Approval**
EXECUTIVE DIRECTOR:	Michelle Turner, Director of Workforce and Marketing
AUTHOR(S):	Michelle Turner, Director of Workforce & Marketing
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 approve the Strategy***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable Or type here if not on list: Putting People First Committee		
	Date of meeting	Friday, 30 November 2018		

Executive Summary

The Putting People First Strategy 2019-2024 has been developed in collaboration with staff, partners, volunteers, patients and other stakeholders over the last 6 months. It builds on the achievements of the previous Strategies and seeks to further respond to the key workforce risks, challenges and opportunities facing the Trust and its workforce over the next five years. The Strategy sets out the challenges of the operating context and identifies four key themes integral to the delivery of an engaged and capable workforce:

- Supporting the health & wellbeing of staff
- Engaging & Involving our people,
- Influence & Impact on our community and
- Investing in our people and our leaders.

The strategy sets out the ambition and objectives under each theme and the measures of progress and success. The Putting People First Committee will be accountable for gaining assurance that there is good progress being made in the delivery of the Strategy and will formally review progress every six months. Each Key Theme will have an annual delivery workplan. Divisional performance will be monitored through the Divisional Boards and the people metrics within the Performance Assurance Framework will be refreshed to reflect the revised Strategy.

It is designed to remain fit for purpose for the next 5 years and anticipates that change will remain a major challenge and a highly engaged, flexible workforce is essential if the Trust is to achieve its vision of being the leading provider of healthcare for women, babies and their families.

Report

Introduction

The Trust has undertaken a comprehensive range of scoping and engagement activities with key internal and external stakeholders to inform the refresh of the People Strategy. Strategic ambition, employee feedback, societal drivers and local and national NHS context have also been taken into account to ensure that the People Strategy truly focuses on, and addresses, the key people risks and challenges facing the Trust as it progresses its clinical strategy over the coming five years.

Context and Key Themes

The Strategy is informed by the context in which the Trust operates, and needs to be accessible and relevant to the current and future leadership and workforce. In the next five years:

The workforce will need to be :

- Resilient and responsive to change
- Flexible
- Well led, motivated and engaged

As an employer we will need to be:

- Attractive in a highly competitive market & responsive to the future employee 'ask'
- Flexible in our thinking
- Prepared to work across boundaries be they organisational or professional
- Innovative in our approach to recruitment and retention, reward & recognition
- Fair & Just with a focus on improving safety through learning

In our community we will need to

- Make every contact count
- Be seen as an employer and hospital of choice
- Respond more flexibly and innovatively to the needs of patients and their families
- Be reflective of the community we serve and responsive to their needs
- Provide access to work opportunities in the broadest sense

In summary, the four key themes underpinning the Strategy are:

- Key Theme 1 – Supporting the Health and Wellbeing of our Staff
- Key Theme 2 – Engaging and Involving our People
- Key Theme 3 – Our Influence and Impact on our Community
- Key Theme 4 – Investing in our People and our Leaders

Once approved, a detailed work-plan will be developed to set out year on year delivery objectives and to enable the PPF Committee to more easily track progress and provide assurance to the Board. In addition, and in response to feedback from staff, a simple visual representation of the strategy set in the context of our environment in which

our stakeholders can identify themselves and their journeys will be developed together with a summary of the strategy for wider circulation in the organisation.

Conclusion

The new strategy has been developed following extensive engagement with staff and stakeholders. It is designed to remain fit for purpose for the next 5 years and anticipates that change will remain a major challenge and a highly engaged, flexible workforce is essential if the Trust is to achieve its vision of being the leading provider of healthcare for women, babies and their families.

Recommendation
That the Board of Directors

- Approves the Strategy

Putting our PeopleFirst

NHS
Liverpool Women's
NHS Foundation Trust

Putting People First Strategy 2019-2024

[FINAL DRAFT – November 2018]

Introduction from the Director of Workforce & Marketing

Here at Liverpool Women's we believe a great patient experience is intrinsically linked to a great employee experience. For this reason, we need to care for, develop and enable the collective potential of all our people, including those who are not directly employed but who have an important role to play here at the Women's, and harness their energy, ingenuity, talents, differences in a shared sense of purpose.

Our ambition is to create a place of work where everybody

- feels welcomed and their contribution, talent and differences are valued and recognised from the very first to the very last day of their time at Liverpool women's
- is clear about the part they play in the delivery of excellent and safe care every day
- Understands their personal responsibility to ensure they have a positive impact on those they care for and those they work alongside
- has a voice, is encouraged to speak up without fear of blame in the interests of patients and receives timely feedback on their ideas and concerns
- is actively encouraged to get involved in shaping improvements in their service areas and teams
- is actively involved in decisions that affect them
- is supported to develop throughout their career to achieve their full potential
- is treated fairly and with respect, with a shared commitment to learning from the times when we don't get things right
- is led by leaders and managers who truly understand and are committed to supporting their teams to do the very best they can for women, babies and their families
- actively seeks feedback from patients, visitors and colleagues to inform their personal and professional development
- feels supported, cared for, empowered and proud to work for and recommend Liverpool Women's as a place to come for care
- lives up to the values of We Care & Learn and consistently demonstrates the right behaviours

We believe there are four key themes which are at the very heart of ensuring Liverpool Women's is a great and safe place to work. These are

- Health & Wellbeing
- Engagement & Involvement
- Influence & Impact in our communities
- Compassionate Leadership – Investing in our People and our Leaders

Our Vision

The vision for Liverpool Women's is to be the recognised leader in healthcare for women, babies and their families.

Our Strategic Aims

The strategic aims give the trust the direction needed to deliver the trusts vision of being the recognised leader in healthcare for women, babies and their families. Our five strategic aims are:

1. To develop a well led, capable, motivated and entrepreneurial workforce.
2. To be ambitious and efficient and make the best use of available resources.
3. To deliver safe services.
4. To participate in high quality research in order to deliver the most effective outcomes.
5. To deliver the best possible experience for patients and staff.

We know that it is not what somebody does but how that task is performed that really makes a positive difference to how our patients, service users and our staff experience our services.

Strategic Context - The Big Issues

Future Generations

The Trust's clinical strategy 'Future Generations' clearly sets out the vision for Liverpool Women's services for the future, with the aim of ensuring clinical staff have access to the full range of clinical support services and timely access to other specialist clinical expertise. We are now experiencing the anticipated challenges in recruiting and retaining highly specialised medical staff, particularly in oncology and anaesthetics, requiring us to work creatively with colleagues across the city in terms of recruitment of Consultant staff and the sharing of facilities such as Theatres and ITU.

Whilst we remain focused on securing a significant capital investment to fund the relocation of Liverpool Women's hospital adjacent to the main adult acute hospital in the city, and anticipate a period of public consultation in the first years of this Strategy, we must continue to work collaboratively with other partners to ensure the delivery of safe care to women in the time leading up to any future relocation.

Work has commenced on a £15m investment in our neonatal unit to provide an improved clinical estate and we continue to work collaboratively with our partners at Alder Hey to provide a single neonatal surgical service, where specialist surgeons are supported by our specialist neonatologists and nursing teams.

Fair & Just Culture

We listened carefully to our workforce when they told us that they did not always feel confident about being treated fairly when they were involved in an incident or a complaint. We want to drive a safety culture, based on fairness and learning. This year will see the formal launch of the Trust's Fair & Just Culture Programme. This is a long -term programme of cultural change, working closely with an international expert on developing safety cultures – David Marx – to ensure we embed a culture where the focus is on clear accountability, supporting each other and learning from events. In the lifetime of this Strategy, the Fair & Just culture will become everyday currency – the way we do things round here - under-pinning all of our employment practices and leadership behaviours.

Quality delivered through efficiency

The NHS workforce is accustomed to challenge and change. In addition to the challenges faced by all healthcare providers in ensuring high quality services in a climate of increasing demand and patient expectation at a time of financial constraint, there is an increased focus on improving public health. Such a major transition is challenging and will require courage, energy and innovation from all within the service at every level. We will learn from others within in the Service, and from industry, in our drive to ensure we are as efficient and lean in our processes as we can be, striving to eliminate any waste of our people's time and our valuable resources. Service improvement will be at the heart of our drive for efficiency, with teams encouraged and empowered to make positive change in the interests of patients. We recognise our duty to support and engage with our staff through change, ensuring they are resilient and open to new ways of working, whilst at the same time listening carefully to their ideas and concerns.

Flexibility & Wellbeing

We need to ensure we are supporting our workforce to be fit and well for the future both mentally and physically as we all face the prospect of longer working lives and increased workforce challenges. We need to adapt our approach to the changing needs and desires of the younger generations and develop more flexible and agile working solutions for all generations working in healthcare. In the lifetime of this Strategy we will increasingly see our staff working across service, professional and organisational boundaries. We will need to ensure staff are well supported, skilled and confident in their abilities to work flexibly across organisations and systems, and equally that we are responsive to enable staff from other organisations to deliver care here at Liverpool Women's.

We will learn from our workforce and from others on how we can improve the deployment of staff and use technology to improve the working lives of our people.

We remain concerned that one third of our workforce report occasionally feeling unwell due to stress. This strategy will continue our focus on improving mental health at work through a range of positive interventions, support and improved leadership behaviours.

Compassionate Leadership & Caring for each other

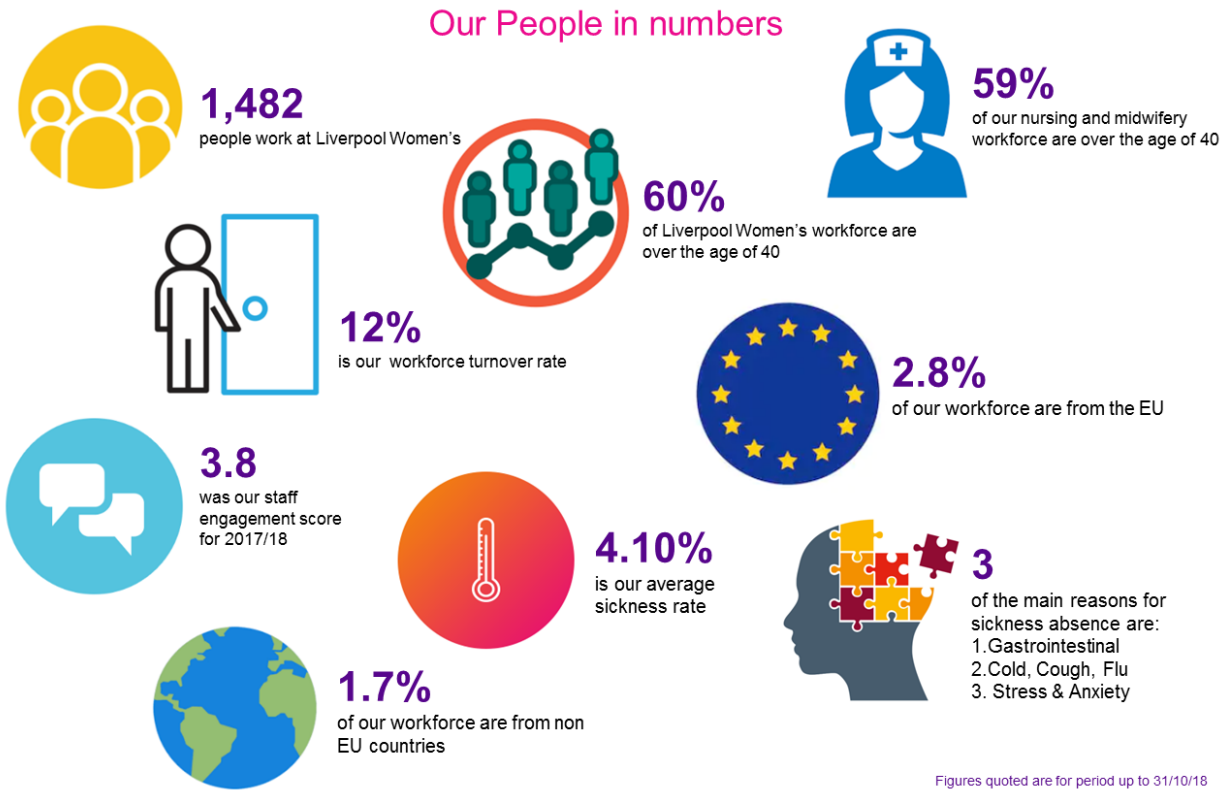
This is a time of great leadership challenge in the NHS at every level. We will invest in the identification and development of emerging and existing leaders, and ensure that they are well equipped to care for their staff so their staff can care for patients and their families. We are committed to every employee and volunteer feeling cared for, able to care for each other and proud to work at Liverpool Women's.

Brexit

The political uncertainty associated with Brexit has consequences for healthcare. This strategy will require us to pay close attention to the strategic workforce implications arising from the progress of Brexit. We will need to focus on ensuring our staff from the EU and overseas are well informed and supported at this time, and that we – together with partners in the city and beyond – are addressing any risks and deficits arising from Brexit as well as seizing opportunities for working differently and growing the workforce of the future.

Recruitment & Retention challenges

We need to remain focused on planning and working collaboratively with other partners in health and education to ensure we have a talent pool of staff to deliver our services for the future. Changes to medical education, the removal of NHS bursaries for nurses and midwives and the challenges we face as a specialist tertiary centre working on an isolated site requires us to think innovatively about how we remain attractive in a highly competitive market to ensure we can continue to recruit and retain staff of the highest calibre.



Figures quoted are for period up to 31/10/18

Developing our People Strategy

The people best placed to inform the development of a five-year People Strategy are those who work and volunteer for Liverpool Women's and those who use our services. We have over the last 12 months developed this strategy in partnership with our staff, our trade union partners, our patients and their families and our Governors and Members.

We know that our workforce will need to be:

- Resilient and responsive to change
- Flexible & innovative
- Well led, positive, motivated and engaged

We know that as an employer we will need to be:

- Attractive in a highly competitive market and responsive to the future employee's 'ask'
- Flexible in our thinking and approach to work
- Prepared to work across boundaries, both professional and organisational
- Innovative in our approach to, recruitment, retention, reward and recognition
- Fair & just with a focus on improving safety through learning

In our community we will need to:

- Make every contact count
- Be seen as an employer and hospital of choice
- Respond more flexibly and innovatively to the needs of patients and their families
- Be reflective of the diverse community we serve and responsive to their individual needs
- Provide access to work opportunities in the broadest sense

Through this development process we have together identified four key themes on which we will focus over the next five years as we transition to the next phase in the history of Women's services in Liverpool.

- Theme 1 - Supporting the Health & Wellbeing of our staff
- Theme 2 - Engaging and involving our people
- Theme 3 - Increasing our influence & impact in our communities
- Theme 4 - Compassionate Leadership - Investing in our people and our leaders

Supporting the Health and Wellbeing of our staff

Our Ambition

To create a workplace in which staff are healthy, resilient, engaged, motivated and show initiative, and who are actively involved with the Trust. A workplace where physical, mental and emotional health and wellbeing is at the heart of the employment relationship, and everyone is committed and supported to care for themselves and for their colleagues.

How we will do this

1. We will ensure that promoting and ensuring wellbeing is seen a positive leadership behaviour – embedded in our leadership training, our PDR processes and our staff engagement measures of success; we will celebrate the achievement of those who embrace the wellbeing challenge in their leadership, and support others to be even better

2. We will invest in building resilience in our workforce, through formal access to training, development and support and by ensuring that leaders truly engage and involve their teams in times of change, giving real opportunity for input and influence early in the change process – a 'do with' rather than 'do to' mindset

3. We will continue to develop our Mental Health First Aider offer to ensure all teams have easy access to a mental health first aider. We will commit to maintaining at least 10% of our workforce as trained Mental Health First Aiders and we will commit to support other organisations at the start of their Mental Health First Aider journey

4. We will offer dedicated training to line managers on how to have open and supportive conversations with individuals and teams about mental health, as part of a wider Challenging Conversations development offer

5. We will actively promote uptake of our Listening to our People tool, to ensure managers have timely engagement feedback from their teams to inform local engagement activities

6. We will continue to develop our Health & Wellbeing programme, with an increased focus on opportunities for physical activity and mental wellbeing, seeking innovative technological solutions to enable staff to be able to access health & wellbeing activities at a time and place that suits them. We will commit to the Workplace Wellbeing Charter and Workplace Health needs Assessment process

7. As part of our Fair & Just Culture Project, we will refresh our attendance management processes moving to a language of support and enablement, with an increased focus on prevention and improvement, with appropriate training for line managers

8. We will recognise and celebrate the achievements of those at every level who have a positive impact on others health and wellbeing

9. We will ensure staff wellbeing considerations are built into all planning and change processes, recognising its importance in developing a Healthy Workplace for all our People.

10. We will identify practices and solutions that show staff we care for them personally and develop and prioritise facilities and services to help staff manage work and home more easily, and achieve the right balance.

11. We will work with our Occupational Health Practitioners and those who are expert in the field to develop further innovative and engaging health education programmes in our organisation to bring about lifestyle changes for the benefit of staff and patients

12. We will work with new and existing employees to develop a shared understanding and commitment to the importance of being happy, positive and kind to each other, especially at times of pressure and change

Engaging and involving our people

Our Ambition

To create an inclusive working environment, where differences are recognised and valued. A listening and respectful culture, enabling the voice and views of staff to inform and drive improvement, change and learning. A fair and just workplace that supports staff to speak out in the interests of patients and each other, and supports people when things go wrong, with a primary focus on learning from experience.

How we will do this

1. We will recognise the expertise that lies within our teams, and nurture this through leadership and management development programmes. We will, through an agreed quality improvement methodology and training, empower local teams to own and drive service improvement in their areas of expertise

2. We will introduce organisational systems and processes that support rapid innovation and improvement, and we will be brave when it comes to scaling up successes for the benefit of the wider organisation

3. Under the auspices of the Fair & Just Culture Programme, we will actively counsel and coach staff who have been involved in incidents or complaints resulting in harm or potential harm. Managers and leaders will be required and supported to develop their coaching and mentoring skills, both informally and formally, internally and externally and staff will be actively involved in developing and identifying solutions.

4. We will establish processes that make it easier for staff to put forward innovative and creative ideas for exploration and testing, ensuring ongoing feedback and opportunities to be involved with and own 'testing' of innovation

5. We will move swiftly to address any perceived tensions between targets, finance and patient care and will ensure that we have a shared purpose where everybody's contribution to the delivery of safe, effective and efficient patient care is recognised and understood.

6. We will work collaboratively with partners to develop a networked approach to continuous improvement across organisational boundaries in recognition of the challenges of system-wide working

7. We will ensure our leaders recognise the individual needs of staff which, when addressed with a flexible and innovative mind-set, can ensure the Trust continues to benefit from their skills and talent.

8. We will ensure that there are clearly signposted routes for staff to raise concerns and speak out in the interests of patients and each other; with a focus on listening and feedback and open appreciation of those who speak out

9. We will improve our internal communication processes and skills, utilising technology to support but not replace face to face dialogue, with an increased focus on feedback and sharing of messages

Influence an impact on the community

Our Ambition

To have a thriving and diverse volunteer workforce and membership, reflective of our community and our patients. A workplace which is attractive, accessible and welcoming to those thinking about healthcare careers or work in the wider sense. A workplace where our staff are encouraged to reach out of the workplace and influence and improve health through community-based projects.

How we will do this

1. We will work with our teams and our local community, to ensure our workforce, from Board to Ward, is representative of our community in respect of all protected characteristics and we will be proactive in identifying, developing and promoting role models from diverse backgrounds.

2. We will improve organisational and individual awareness of cultural difference, including unconscious bias and will identify innovative ways to improve diversity in attraction, recruitment and development processes.

3. We will continue to innovate in our work experience programmes, engaging with schools, colleges and other organisations, with a particular focus on addressing barriers to employment and establishing non-traditional routes to qualifications and employment

4. We will continue to develop our volunteering offer, being flexible in our approach to meet the individual and diverse needs of potential volunteers, with an eye to the potential for progression into healthcare careers through a clearly defined pathway.

5. We will further develop and extend our vocational learning programmes

6. We will work to maintain contact and relationships with potential employees, to ensure they look first to Liverpool Women's when looking to take up or resume a healthcare career

7. We will ensure our staff are supported and trained to provide cultural and social support for our patients, by improving staff understanding of cultural and community needs.

8. We will ensure we listen carefully to the voice of our community, providing regular opportunities for dialogue and by evaluating the feedback (informal and formal) we receive through a range of measures

9. We will ensure that every member of staff at Liverpool Women's understands the importance of making every contact count and their role in promoting good health, not only through formal healthcare interactions but through innovative interactions such as social prescribing, literacy projects, volunteering projects, talks and events.

10. We will identify opportunities for our staff to get involved in the community we serve, and support our staff to ensure that every contact counts with a focus on health, wellbeing, ambition and safety.

Investing in our people and our leaders

Our Ambition

Where everybody is proud and happy to work for Liverpool Women's and will without hesitation recommend it as a place to work and a place to come for care. We are the preferred employer of choice for potential colleagues of the future.

Where leaders proactively care for their teams, consistently displaying the organisation's values and expected behaviours without fail.

Where talent of the future is identified and nurtured to achieve their full potential and our teams are coached, empowered and supported to improve every day.

How we will do this

1. We will develop a Leadership Strategy which promotes collective, compassionate and visionary leadership

2. We will further develop our talent mapping processes – ensuring that through effective appraisal discussions talent and aspiration is identified and nurtured to ensure a pipeline of Liverpool Women's leaders in all areas and disciplines

3. We will develop a multi disciplinary Leadership Forum to aid self-development, peer support and networking across the organisation and across the system. This will include buddying and mentoring for new leaders and facilitated connections to wider networks including the National Leadership Academy.

4. We will enhance our appraisal system for managers and senior leaders to include 360 feedback and to include team engagement performance as measured by the Listening to our People Quarterly Survey.

5. We will continue to invest time and energy in the Fair & Just Culture Programme, training leaders and managers across the organisation in the methodology and requiring them embrace and consistently role model the behaviours to be found in a fair & just culture.

6. We will develop and roll out a Coaching & Mentoring Programme with a mixture of formal coaching training, coaching behaviours and team coaching; and a focus on growing an internal cohort of mentors

7. We will ensure that newly appointed line managers have access to support, training, development and mentoring for the first 12 months in the form of a personalised programme

8. We will expand and promote our 'aspirant' offer to those looking to progress into leadership roles, including the medical workforce.

9. We will celebrate and recognise great leadership through our formal recognition process

10. We will look outside of the NHS to identify exemplary employers and seek to give our leaders exposure to those environments and their leadership behaviours

How will we know we are making progress?

We will focus on three annual measures of progress

- Staff advocating Liverpool Women's as a place to work and be treated (Listening to our People Survey/Staff Friends and Family Test)
- Staff engagement (Annual Staff Survey)
- Staff motivation (Annual Staff survey)

The metrics we will measure throughout the lifetime of the Strategy at an organisational, divisional and directorate level are

Health and Wellbeing

- Improved attendance
- Reduced time lost due to Work related Ill Health (specifically absence stress related & MSK absence)
- Improvement in staff health outcomes over long term (measured by reduced long term sickness)

Recognition

- Investors in People – Accreditation & Awards
- Times Best Employer status
- Outstanding "Well Led" CQC rating
- Success at local and national awards
- Ward Accreditation Programmes
- Workplace & Wellbeing Charter

Diversity

- Improvement in equality goals as measured by Equality Delivery System (EDS) and Workforce Race Equality System (WRES) with a particular focus increased representation in management and leadership roles
- Workforce more representative of the community we serve

Productivity

- Reduced agency and bank spend
- Improved performance against Lord Carter's benchmarks from the Operational Productivity and Performance: Unwarranted Variation report

Employer of Choice

- Reduction in long term vacancies
- Reduction in turnover in hotspot areas
- Increase in number of apprenticeships, advanced practitioners and other enhanced roles
- Positive feedback from healthcare students (GMC Survey, HEI Feedback, SAR)
- Increase in confidence level about being treated fairly when things go wrong (Annual Staff Survey)

Development

- Improved leadership behaviours & management skills (as measured through the Listening to our People Quarterly Surveys & annual staff survey)
- Increasing rate of quality appraisals (as measured by annual staff survey)
- sustained improvement in staff training rates both mandatory and non-mandatory
- Improved talent management (measured by internal promotion)
- Improved team working (as measured by annual staff survey metrics)
- Increases in staff undertaking quality improvement training
- Increasing number of staff accessing coaching, mentoring and team development

Who is responsible for reviewing the progress and impact of the strategy

Progress against the strategy will be reviewed every six months by the Putting People First committee who will provide assurance to the Board of Directors.

Divisional performance against the Strategy will be monitored through the Divisional Boards, providing assurance to the Trust Management Group.

Key people metrics will form part of the Trust's overall Performance Management Framework

Putting our PeopleFirst

Agenda Item	2019/015 (1)

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Bi-Annual Nursing & Midwifery Staffing Report January 2019**
DATE OF MEETING:	Friday, 1 February 2019
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Caron Lappin, Director of Nursing and Midwifery
AUTHOR(S):	Caron Lappin, Janet Brennan
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: *1. Accept the assurance of the current nurse/ midwife staffing levels* *2. Note the content of the report and the assurances provided that nurse/midwife staffing levels are safe and appropriate at present.* *3. Note the risk to the organisation of the number of nursing and midwifery staff > 50 years of age.* *4. Be cited on the national shortage of nurses and midwives.*			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Putting People First Committee		
	Date of meeting	25 January 2019		

Executive Summary

The bi-annual Nursing and Midwifery staffing report is provided to the Board of Directors through the Putting People First Committee. The report sets out the LWH position in the context of the National Nursing and Midwifery workforce challenges. The paper covers the period from June 2018 to December 2018. The paper provides assurance that there are robust systems and processes in place throughout the year to monitor and manage nursing & midwifery staffing requirements.

Getting the right numbers of nurses, midwives and care staff in place is essential for the delivery of safe and effective patient care. It is a requirement for the executive Nurse Director, on behalf of the Board of Directors to review the nursing and midwifery staffing numbers twice per year.

NHSI have developed new recommendations to support Trusts in making informed, safe and sustainable workforce decisions (October 2018). The document builds on the National Quality Board's (NQB) guidance (2013, 2016). NQB's guidance states that providers:

- Must deploy sufficient suitable qualified competent, skilled and experienced staff to meet the care and treatment needs safely and effectively.

- Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of the people using the service and keep them safe at all times.
- Must use an approach that reflects current legislation and guidance where it is available.

In 2017 the NQB published an improvement resource to achieve safe, sustainable and productive staffing of maternity services. The guidance endorses Birth-rate plus as a tool to ensure staff are deployed in the right place whilst NICE guidance supports 1:1 care in labour.

LWH reports the following in line with NQB recommendations:

- 6 monthly Trust Board report: Bi- annual Nursing & Midwifery Staffing Review.
- Monthly Board level reporting detailing planned and actual staffing for the previous month.
- Monthly staffing report to Unify and published on the Trust's website, and the NHS Choices website.
- Nursing/ Midwifery staffing levels each shift (planned and actual) displayed at ward level.
- Evidence based tools, professional judgement and outcomes are used in the safe staffing processes.
- Updated annual workforce plan that is signed off by the Executives.
- Any service change, including skill mix change has a full quality impact assessment review signed off by the DONM and MD.

The report highlights:

- Birth-rate plus ratios are in line with national guidance.
- NICU has introduced a safe staffing tool utilised 4 times a day to ensure safe staffing levels.
- Theatres establishment follows Association for perioperative Practice (AFPP) guidelines.
- The Trust has joined NHSI cohort 4 – reviewing retention with a 90 day turnaround programme.
- CHPDD shows : LWH average is 11.1 hrs per day spent with patients compared to 12 hrs (Peers) and 11.1 hours (national) based on the Model Hospital Data (October 18).
- Gynaecology has a new HON who is undertaking an in depth review of nursing across all of Gynaecology areas.
- Actual versus planned staffing shows: Fill rate is consistently >84% for both Registered and care staff.
- Vacancy rates are below the national picture.
- The Age profile for LWH - 30 % of the Nursing and Midwifery workforce are > 50 years of age.

The Board is asked to receive this paper and to agree the recommendations.

Report

1.0 Introduction

1.1 This bi-annual comprehensive report is provided to the Board of Directors on Nursing and Midwifery staffing. The report details the Trust's position against the requirements of the National Institute of Health Care Excellence (NICE) guidance for adult wards issues in July 2014, the National Quality Board (NQB) Safer Staffing Guidance 2016 and the NQB speciality staffing improvement guidance documents published by NHSI in January 2018.

1.2 The paper will provide analysis of the Trusts workforce position at the end of December 2018 and the actions being taken to mitigate and reduce the vacant position

1.3 Workforce modelling has been undertaken by each division

1.4 *Safer Nursing Care Tool (SNCT) and CHPPD* are utilised in adult inpatient areas (Gynaecology Wards) which calculates the care requirements of patients based on their acuity and dependency scores. The staffing and acuity measures are modelled twice yearly. Birth- rate Plus and professional judgements are used to determine appropriate midwifery staffing. In addition the maternity delivery suite utilise an acuity tool every two hours to assist with staffing. The Neo-natal unit has also recently implemented an acuity model of staffing, which is reviewed 12 hourly and staffing flexed in accordance with patient need. British Association of Perinatal Medicine (BAPM) standards have been utilised to provide the benchmark for staffing within the Neo-natal Unit. Theatre staffing review is based on AFPP (Association of peri-operative practitioners) guidelines.

1.5 Genetic services and Reproductive Medicine were also reviewed. There are no approved tools for the assessment of safe staffing of these services, however the services provided are predominantly clinic based, within Genetics and therefore staffing levels were determined in response to the service demand and clinic provision time required. Reproductive Medicine uses RCN staffing guidance, however it is difficult to benchmark nursing staffing levels and establishment against local fertility providers, as at LWH it is mainly nurse led as opposed to a medical led service within the region.

1.6 In the review of establishments, the ongoing monitoring of nursing and midwifery quality indicators, red flags, patient survey results, friends and family feedback, reported incidents and complaints have all been taken into account to assess whether the nursing and midwifery needs of patients are being met. These are presented monthly at Board and relevant senates and demonstrate good compliance.

2.0 National Context

2.1 The shortfall in nurse numbers and midwives across the UK is well- recognised. Although there is no nationally agreed measure of the shortfall in the nursing in England, recent figures presented by NHSI suggest the number is circa 43,000 vacancies and 3.500 Midwives.

2.2 There has been a 20% increase in nurses and midwives leaving the profession; for the first time in 2016/17 the number of leavers has outstripped the number of nurses joining the NMC register and 45% more UK registrants left the register in 2016/17.

2.3 There has been a reduction in the student nurses and student midwives commissions between 2009 and 2012 alongside the removal of bursary payments for students from 2017 which has resulted in a 20% reduction in the number of applicants applying to undertake nurse training and a reduction of 6% on pre-registered students commencing nationally.

2.4 The uncertainty of the impact of Brexit has had an influence in the significant reduction of EU Nurses & Midwives applying to join the register.

2.5 An aging workforce profile predicted to reach retirement age within the next 6 years.

2.6 A reduction in Continual Professional Development funding (CPD) impacting on training and development opportunities for the Nursing and Midwifery workforce.

2.7 Cheshire and Mersey Vacancy position (9.3%) and the national position (11.6%) is illustrated in the table below.

3.0 LWH Workforce position

3.1 At the end of November 2018 there were a total of 31.54 (4.91 %) registered nursing, midwifery and ODP vacancies across LWH. Compared to Cheshire and Mersey (9.2%) and the national picture (11.6%) LWH is excellent.

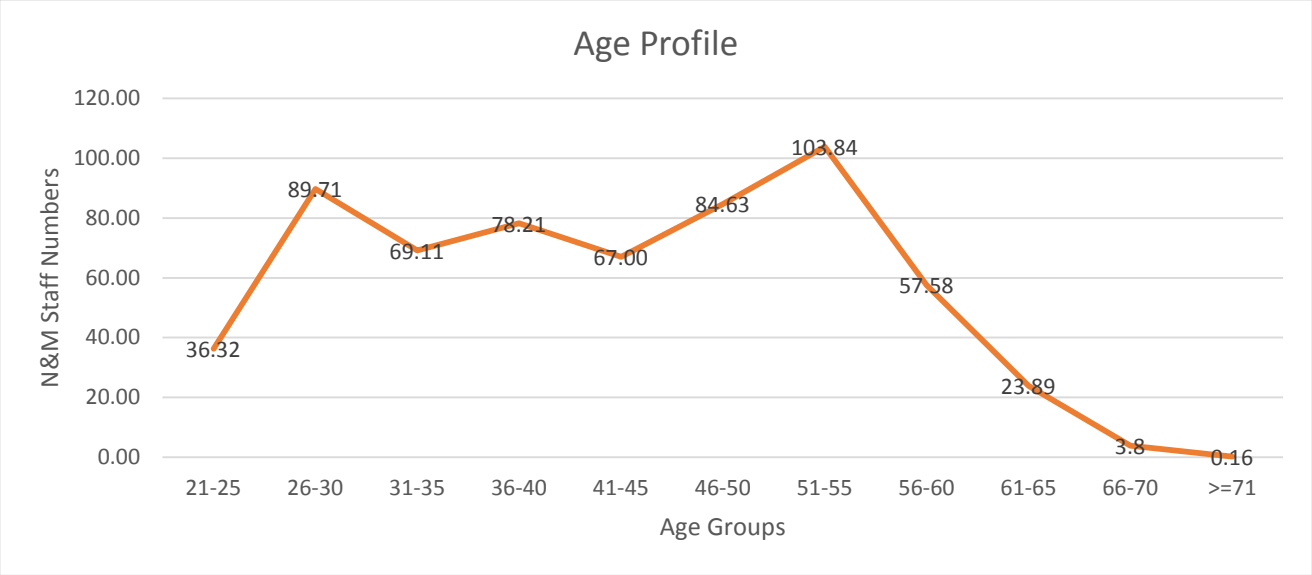
3.2 The table below illustrates the vacancies, turnover and absence by division (November 18).

RN&M / ODP vacancies	Establishment	In Post	Vacancies	Vacancy rate %	Turnover	Absence
Total	642.45	610.91	31.54	4.91	12.2%	7.06 %
Maternity	286.89	285.52	1.37	0.48	6%	5.16%
Gynaecology	93	82.06	10.94	11.76	15%	6.42%
Neonates	158.63	151.78	6.85	4.32	12%	4.06%
Hewitt	33.28	28.19	5.09	15.29	11%	9.62%
Genetics	12.8	10.4	2.4	18.75	11%	0%
Theatres RN	29.13	28.29	0.84	2.88	17%	5.67%
Theatre ODP	23.03	17.35	5.68	24.66	Included in Theatres RN	Included in Theatres RN
Other (Corporate & Support)	28.72	24.67	4.05	14.10	14%	13.45%

3.3 Nursing and Midwifery turnover at the end of November 2018 was 12.2% compared to 15% across Cheshire and Mersey.

3.4 There are 24 Registered Nurses/ Midwives in the pipeline to commence in post in the next few months and 9 unregistered staff.

3.5 Age Profile - the graph below illustrates the age profile of Nurses and Midwives across LWH. 185.31 wte of our N&M workforce are between 51-65 years of age which equates to 30% of LWH workforce.



4.0 Summary of outcomes from Bi- annual review (December 2018)

4.1 Gynaecology services

Areas of challenge relating to staffing are:

- The Hewitt Centre particularly in Knutsford of which there are recruitment action plans in place and a change of leadership with a focus on management.

- There are also Workforce reviews which are currently being undertaken by the newly appointed HON for Gynaecology to enable a divisional view of Nursing across all of gynaecology including outpatients and Bedford looking at different nursing models. Generally across the Division a number of areas will require succession planning given the age profile of the current workforce which is being considered as part of the review by the HON.

- CHPPD data for the Gynae Ward shows an average of 5.68 hrs spent with the patient per day compared to 8.09 (peers) and 8.30 (national) based on data from the Model Hospital (October 18). This will be reviewed in more depth as part of the workforce review. However, a review of the data from Aug-November shows an average of 7.1 hours per patient per day. It is important to note that the use of CHPPD will only capture the care hours provided to each bed and does not capture all the activity on the ward such as the turnover of patients through that bed within the 24 hour period or recognise the acuity of the patient receiving the care. CHPPD measures must be reviewed alongside patient acuity and dependency data and professional judgement as CHPPD is not a metric to either determine registered nurse requirements or to provide assurance for safe staffing by itself. The data will be reviewed as part of the workforce review by the HON.
- Recent turnover is a particular concern at 15% on the ward and the HON is holding listening events to understand the reasons for this.

- The Gynaecology emergency department operates on staffing levels based on in the main professional judgement, knowledge of services and activity needs. There has also been development of the role of the ENP in the emergency department, where there are now 4 trained ENPs with an additional 2 in training.

4.2 Theatres

The service operates on staffing levels based on guidance and methodology from the Associate of perioperative practitioners (AFPP) which is the national standard for staffing operating theatres. A review has been undertaken to ensure that the current agreed establishment meets the requirement.

The role of the First surgical assistant has been introduced and theatres have successfully trained 3 members of staff in this extended role, all achieving qualifications through Edge Hill University. These additional roles are undertaking the role of the junior doctor when required during the perioperative stage. It is intended that these posts will also offer support maternity services. Changes in practice and guidance within the midwifery staffing cohort and NHSI advice has meant previously there has been a reliance on this staffing group to support theatres out of hours. This is no longer advised and this is currently being worked through.

4.3 Maternity

In 2017 the NQB published an improvement resource to achieve safe, sustainable and productive staffing of maternity services. The guidance endorses Birth-rate plus as a tool to ensure staff are deployed in the right place whilst NICE guidance supports one to one care in labour. The table below shows LWH midwife to birth ratio. The table demonstrates this complies with national recommendations of 1:28. Included in this is community and is based on the total midwifery requirements required to care for women and on a minimum standard of providing 1:1 care in established labour. Birth-rate plus is endorsed by the RCM and RCOG.

	June 18	July 18	August 18	Sept 18	Oct 18	Nov 18
BR ratio's	1:27	1:28	1:26	1:26	1:26	1:26

A workforce assessment was commissioned by LWH maternity unit in July 2018 by Birth- Rate plus. This assessment concluded that based on 8200 births. The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non- clinical midwifery roles and skill mix adjustment of the clinical staffing. The results showed that there was a shortfall of non- clinical midwifery posts in comparison to organisations of other sizes. However professional judgement by the HOM reports that the funded establishment with the clinical activity is manageable apart from a requirement for EON midwives (Examination of the New-born) which is being worked through.

Staff turnover has been consistently below the trust target, in November 2018 it was 6%. Although the vacancy rate is nil, many are newly qualified midwives which is challenging as the level of experience and expertise takes time to develop. The role of Deputy Head of Midwifery has been introduced to strengthen the midwifery leadership team.

4.4 Neonatal Services

In line with other intensive care specialities BAPM has set clear standards about the minimum number of nurses required to care for neonates in intensive care. 2018 has seen the introduction of the safer staffing guidance for Neonatal services, this reflects the requirements of the BAPM guidance but also addresses that professional judgement should be used. According to BAPM standards with a 25% uplift then the unit should have 124 bedside nurses wte in post there are 117.47 wte. The unit can struggle to meet the nursing ratios on a day to day basis and this is due to the current environment and the occupancy of HD and IC

which often run on or above the 80% commissioned occupancy. Staffing and Acuity are monitored by the shift co-ordinator and twice a day on the Badger system.

4.5 Genetics

There is no national workforce tool for determining staffing levels for genetic counsellors: however, there are various guidance which is taken into consideration when planning safe staffing numbers. There is a national shortage of trained genetic counsellors which has been evident in the unsuccessful recruiting to a band 7. There is a plan to advertise but there may be a necessity to employ a band 6 trainee which will have an impact on the genetic counsellor team as there is a significant training burden with a trainee genetic counsellor which takes a minimum of two years.

5.0 Recruitment

Trust wide recruitment campaigns continue to attract experienced nurses and midwives as well as newly qualified Nurses and Midwives. There are circa 24 Nurses/ midwives both newly qualified and experienced nurses/ midwives with conditional job offers whose appointments are being processed through the recruitment process. The HON/ M have introduced keep in touch strategies for those in the recruitment process.

6.0 Retention and Turnover

6.0 Retention is a key element of the workforce plans for the Trust. At the end of November 2018, the Nursing and Midwifery turnover rate was 12.2 %.

6.1 LWH have joined Cohort 4 of NHSI work regarding retention. Reports on this will be through Nursing and Midwifery Professional Forum and is a 90 day turnaround programme.

7.0 Care Hours Per Patient Per Day (CHPPD)

7.1 In May 2014, guidance was published from NHSE that required all Trusts to publish staff fill rates by hours (Actual versus Planned) via the unify report. From April 2016 all Trusts were required to report monthly staff fill rates and Care Hours per Patient Day (CHPPD) via unify.

7.2 CHPPD was introduced as a measure for the deployment of nursing, midwifery and healthcare support staff on acute and acute specialist inpatient wards. CHPPD is now the national principal measure.

7.3 CHPPD is calculated by taking all the shift hours worked over the 24-hour period by Registered nurses/ midwives and nursing assistants and dividing this by the number of patients occupying a bed at midnight. The data is aggregated each day over the month. In maternity only, the mothers are included in the census.

7.4 It is important to note that the use of CHPPD will only capture the care hours provided to each bed and does not capture all the activity on the ward such as the turnover of patients through that bed within the 24-hour period or recognise the acuity of the patient receiving the care.

7.5 The lack of national CHPPD benchmarks limits the validity of the data to inform safer staffing decisions at present.

7.6 Whilst CHPPD is a simple measure, this must be reviewed alongside patient acuity and dependency data as CHPPD is not a metric to neither determine registered nurse requirements not provide assurance for safe staffing.

7.7 Appendix 1 illustrates CHPPD level from July 2018- November 2018. The data shows that:

	Average hours per day spent with Patients
Delivery suite	24.1hrs
Maternity Base	6.52hrs
MLU & Jeffcoate	31.96hrs
Neonatal unit	12.98hrs
Gynaecology Ward	7.1hrs

The above data must be treated with caution as described in the points above. The data appears to reflect what is required however; apart from the gynaecology ward benchmarking with peers is unavailable at this time.

8.0 Safe care-Planned versus actual

8.1 Planned versus actual staffing levels are reported monthly via Unify. Currently the data is gathered manually it is envisaged producing this information via Health roster by the end of Q1.

8.2 Appendix 1 shows the planned versus actual figures from July 2018- November 2018. The data shows that the fill rate is very good. Averages for RN/M and care staff fill rate is > 85%.

9.0 Safe care-Acuity and dependency

9.1 The Safer Nursing Care Tool (SNCT) has been used on the Gynaecology ward for a period of 1 week to calculate the care requirements of patient based on their acuity and dependency scores. Going forward this will be carried out twice yearly. The point prevalence is based on the Shelford Group tool but must be used with professional judgement. It must also be noted that this tool is calculated using a headroom of 22%. Also, the Gynae ward at LWH includes day cases and the tool is designed for in patients only. It should be noted that the point prevalence does not include the High dependency unit or the day case trolleys. The results are unable to define the correct establishment needed for the ward due to the mix of day cases and in patients but has given an indication for the HON to use as part of the workforce review. What is has shown that the majority of patients in the period monitored were either level 0 (needs met by normal ward care) level 1a (acutely ill patients requiring intervention e.g. observations, post- operative complex surgery)

9.2 The SCNT does not differentiate between Registered and support staff hours therefore the analysis does require a good understanding of the patient population: professional judgement is an important factor to be considered when making decisions about safe staffing

9.3 The tool is not designed to capture acuity and dependency data from wards with less than 16 beds, day case rates, maternity areas or departments.

10.0 Red Flags and escalation

10.1 Where a shortfall in Registered Nurses/ Midwives occurs, the Trust has a process to mitigate in real time through interventions by senior nurses/ midwives in line with an escalation process to enable the delivery of safe and effective patient care.

10.2 NICE guidance recommends that the Trust have a mechanism to capture "red flag "events. The Trust has incorporated these into the Trust incident reporting system. Incidents can be reviewed against acuity and dependency and planned and actual staffing levels for the day. Triangulation of data assists in informed decision making relating to staffing. LWH participates in and publishes data relating to NHS Safety Thermometer Classic and Maternity.

10.3 From July 2018 a total of 83 Red flags were raised. 14 of these were incidents reported as staffing shortfalls.

10.4 The top 3 reporting areas were delivery suite, delivery suite induction room and neonatal unit. Delivery suite- 20 relating to delays in activity and the Neonatal unit 10 relating to errors of administration of medications.

10.5 Staffing levels are also triangulated with complaints and adverse incidents to provide assurance on patient safety; staff are encouraged to complete an incident report when staffing levels are below the required parameters. Daily huddles take place for the site to review staffing levels.

11.0 E-Roster

11.1 The Trust has rolled out Health Roster, there is still some work to do with embedding usage of the system. Health roster challenge meetings with DDON/M, monitoring the roster performance KPI's with the HON/M and matrons .This is being rolled out In January 2019. This will be then led by the divisions in March 2019.

12.0 Temporary staffing

12.1 Currently the Trust uses its own internal Bank system. A scoping exercise will be undertaken in the New Year looking at the feasibility and cost of utilising other bank methods.

13.0 Headroom

13.1 The trust currently fund headroom within operational budgets at 18.9%. Maternity leave is not funded within the headroom calculation. It is recommended that an increase in annual leave allowance and sickness and absence target then the headroom target be increased to 21%. 21.4% for maternity. Birth-rate plus recommend headroom of 22% which is in line with the majority of maternity units in the UK. BAPM recommend 25% however it is recognises that most trust use 22%. There is currently a paper being prepared for a proposal to increase the headroom to 21% across the Trust.

14.0 Summary

14.1 LWH can demonstrate safe staffing levels through workforce reviews, actual versus planned data, CHPPD, acuity tools and professional judgement.

14.2 Vacancy rate at LWH is 4.9% compared to the national picture of 11.6 %

14.3 12.2% turnover compared to 15% across Cheshire and Mersey

14.4 30% of the Nursing and Midwifery workforce are > 50 years of age therefore recruitment and retention needs to remain a high focus.

14.4 The new divisional triumvirate structure will ensure workforce is monitored through KPI's at performance reviews.

14.5 The new HON for gynaecology has already made a difference to understanding the workforce required and will undertake further in depth reviews of all of the gynaecology services.

15.0 Conclusion / Recommendations

Following review by the Putting People First Committee the Board is asked to:

15.1 *Accept the assurance of the current nurse/ midwife staffing levels*

15.2 *Note the content of the report and the assurances provided that nurse/midwife staffing levels are safe and appropriate at present.*

15.3 *Note the risk to the organisation of the number of nursing and midwifery staff > 50 years of age.*

15.4 *Be cited on the national shortage of nurses and midwives.*

APPENDIX 1

Fill Rate/ CHHPD

July 18

WARD	Fill Rate day% RN/RM	Fill Rate day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff	CHPPD RN/RM	CHPPD Care staff	CHPPD Total
Delivery Suite	129.1%	136.8%	112.9%	113.4%	22.9	4.4	27.3
Mat Base	87.1%	76.8%	97.2%	96.7%	4.1	2.0	6.1
MLU & Jeffcoate	73.7%	100%	75.8%	100%	22.7	5.1	27.7
NICU	108.1%	91.9%	109.1%	72.6%	12.5	1.2	13.7
Gynae Ward	95.8%	101.85%	95.45%	103.09%	4.3	3.1	7.3
Average	98.76%	101.47%	98.09%	97.15%			

August 2018

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff	CHPPD RN/RM	CHPPD Care staff	CHPPD Total
Delivery Suite	80.4%	82.8%	85.2%	87.1%	21.6	4.3	25.8
Mat Base	87.9%	77.6%	90.8%	100%	4.4	2.2	6.6
MLU & Jeffcoate	69.9%	100%	72.6%	100%	27.2	6.4	33.6
NICU	110.1%	87.1%	107.7%	85.5%	11.0	1.1	12.1
Gynae Ward	90.8%	102.7%	96.81%	103.23%	4.1	3.0	7.1
Average	87.82%	90.04%	90.6%	95.16%			

September 2018

WARD	Fill Rate Day % RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff	CHPPD RN/RM	CHPPD Care staff	CHPPD Total
Delivery Suite	73.7%	80.0%	89.8%	82.2%	21.3	4.1	25.4
Mat Base	89.2%	66%	98.6%	95.6%	4.3	1.9	6.2
MLU & Jeffcoate	79.4%	100%	74.4%	100%	24.5	5.3	29.8
NICU	107.7%	76.3%	108.1%	98.3%	11.9	1.2	13.1
Gynae Ward	76.3%	95.33%	102.3%	96.67%	3.9	2.7	6.6
Average	85.26%	83.5%	94.64%	94.5%			

October 2018

WARD	Fill Rate Day % RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff	CHPPD RN/RM	CHPPD Care staff	CHPPD Total
Delivery Suite	75.3%	81.7%	84.5%	87.1%	18.0	3.8	21.8
Mat Base	91.9%	76.1%	95.8%	98.9%	4.3	2.1	6.5
MLU & Jeffcoate	72.6%	100%	74.7%	96.8%	24.6	5.5	30.1
NICU	105.4%	90.3%	105.4%	90.3%	10.8	1.2	12.0
Gynae Ward	77.4%	108.06%	97.85%	96.77%	3.7	1.9	5.7
Average	84.52%	91.2%	91.65%	93.97%			

November 2018

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff	CHPPD RN/RM	CHPPD Care staff	CHPPD Total
Delivery Suite	82.2%	81.1%	88%	81.1%	17.0	3.2	20.2
Mat Base	94.6%	78.7%	96.7%	94.4%	4.9	2.3	7.2
MLU	82.9%	90%	77.6%	100%	26.2	5.5	31.6
Jeffcoate	100%	80%	100%	60%	4.1	2.9	7.0
NICU	107.7%	83.3%	105.8%	80%	12.7	1.2	14.0
Gynae Ward	84.2%	101.74%	100%	100%	5.1	3.7	8.8
Average	91.94%	85.8%	94.6%	85.9%			

Agenda Item	**2019/015(2)**

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**
DATE OF MEETING:	1st February 2019
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Colin Reid, Trust Secretary
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.*** *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	**1.** Trust Constitution ☐ **4.** NHS Constitution ☐

STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**2.** Operational Plan ☐ **3.** NHS Compliance ☒	**5.** Equality and Diversity ☐ ***6.*** Other: **NHS England Compliance**
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to note: • The content of the report and be assured appropriate information is being provided to meet the national and local requirements. • The organization has the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Director of Nursing & Midwifery	
PREVIOUSLY CONSIDERED BY:	**Committee name**	***Choose an item.*** Or type here if not on list: ***Click here to enter text.***
	Date of meeting	***Click here to enter a date.***

Executive Summary

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

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

Where there is a variance against planned rates the reallocation of nursing and midwifery resources are implemented where necessary to maintain safe staffing levels.

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 November/ December 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 trust has been developing a ward accreditation system which is required to support the collection of quality indicators alongside real time patient safety flags. Ward accreditation in totality is being rolled out in April 2019 to 5 areas.
- 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 safe fill rates during the month **November 2018.**

The average fill rate for registered staff in Gynaecology was up from October to 84.2 % day time, and 100% night time.

Maternity division displayed an increase in the fill rate as the previous month 89.92 %, however mat base was higher at 94.6% and Jeffcoate 100%.

The inpatient wards have been able to maintain safe fill rates for **December 2018.**

The average fill rate for registered staff in Gynaecology was 87.4% in the day (an increase from November) and 95.6% at night time.

Maternity Division had an average RM fill rate of 88.7% which is a slight decrease from November however MLU and Jeffcoate were higher at 97.6% and 90.3% respectively.

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

November & December 2018 – Red Flags

There were a total of 48 incidents, reported under the Nursing/Midwifery red flag staffing criteria.

10 incidents in total relating to staffing shortfalls across Gynaecology, Neonates and Maternity.

The main themes across the organisation not related to staffing, were delays due to cancellation of activity due to capacity issues and appointments.

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 National information

There is no nationally agreed measure of the shortfall in the nursing and midwifery workforce in England, however, Health Education England state that there are circa 43 ,000 nursing vacancies and 3,500 midwife in the NHS in England.

4.0 Vacancies

There are currently no Midwifery vacancies, 1.6 WTE registered nurse vacancies on the Gynaecology ward however, 4 on maternity leave, and 6.85 WTE band 5 vacancies in Neonates. There are robust recruitment plans to appoint into these posts.

Some appointments that have been offered a conditional job offer are being progressed through the Trusts recruitment process.

Retaining staff is a key element in addressing the workforce position and we commenced a retention programme with NHSI starting in Nov 2018 to review our data and processes around recruitment and retention.

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.

5.0 Summary

During the months of November and December 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. 1:1 care in established labour remains a green KPI, and midwifery indicators such as Breast-feeding rates have seen an improvement in performance.

Gynaecology continues to remain the focus for monitoring recruitment and retention, due to the National shortages of Registered Nurses and a recent increase in leavers. Reporting of incidents are encouraged ensuring that red flags are discussed and acted on with the Gynaecology Head of Nursing and Management team.

6.0 Recommendations

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

Appendix 1

November

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Delivery Suite	82.2%	81.1%	88%	81.1%
Mat Base	94.6%	78.7%	96.7%	94.4%
MLU	82.9%	90%	77.6%	100%
Jeffcoate	100%	80%	100%	60%
NICU	107.7%	83.3%	105.8%	80%
Gynae Ward	84.2%	101.74%	100%	100%

December

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Delivery Suite	82.6%	72.0%	84.9%	71.0%
Mat Base	84.3%	74.8%	82.7%	89.2%
MLU	97.6%	100%	100%	96.8%
Jeffcoate	90.3%	74.2%	80.6%	51.6%
NICU	102.6%	79%	100.4%	80.6%
Gynae Ward	87.4%	92.3%	95.6%	94.1%

Appendix 2

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 (%)
Nov-18	Gynaecology	84.2%	101.74%	100.0%	100.00%

Safer Staffing Fill Rate - Maternity

		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Nov-18	Induction&Delivery Suites	82.2%	81.1%	88.0%	81.1%
	Maternity Base	94.6%	78.7%	96.7%	94.4%
	MLU	82.9%	90.0%	77.6%	100.0%
	Jeffcoate	100.0%	80.0%	100.0%	60.0%
	Maternity Total	86.3%	80.7%	88.5%	85.8%

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 (%)
Nov-18	Neonatal Care	107.7%	83.3%	105.8%	80.0%

Safer Staffing Fill Rate - Gynaecology

		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Dec-18	Gynaecology	87.4%	92.27%	95.6%	94.12%

Safer Staffing Fill Rate - Maternity

		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Dec-18	Induction&Delivery Suites	82.6%	72.0%	84.9%	71.0%
	Maternity Base	84.3%	74.8%	82.7%	89.2%
	MLU	97.6%	100.0%	100.0%	96.8%
	Jeffcoate	90.3%	74.2%	80.6%	51.6%
	Maternity Total	85.5%	76.5%	86.3%	78.6%

Safer Staffing Fill Rate - Neonatal Care

		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Dec-18	Neonatal Care	102.6%	79.0%	100.4%	80.6%

Agenda Item	2019/016

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Performance Report month 9**
DATE OF MEETING:	Friday, 01 February 2019
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**	**Finance Performance and Business Development Committee** **Quality committee**		
	Date of meeting	Monday 21 January 2019 Tuesday, 22 January 2019		

1. Introduction

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

2. Performance

The three 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 87% for November which is the same as reported in September and October. The two locum consultants have revised job plans from January that will start to address the ASI list and then ultimately RRT performance.

The management team are now revising the recovery trajectories previous reported to FPBD in October, 2018.

The number of 52 week breaches in November is now 14. It is anticipated that this will continue to reduce each month eventually to zero by the end of February 2019.

2.1.2 Backlogs

The service has been maintaining consistent queues of 600 for both first and follow ups appointments upto the end of December. The polling range for Uro gynaecology was extended to 10 weeks and with additional capacity from locum consultants and our own teams the ASI (first appointment) has reduced to 250 in January, 2019.

2.1.3 Cancer Targets

All figures for November remain provisional until final sign off via Open Exeter (December 2018) and potential of further impact of diagnosed patients and shared breach allocations with other Trusts.
Confirmed performance for **November** 2018 was as follows:-

- 2 week wait – **Target 93%** - **performance 95.3%** (244 out of 256 patients seen within 2 weeks)
- 31 days DTT – **Target 96% - performance 91.3%** (21 out of 23 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 23.1%** (3.5 out of 13 patients treated within 62 days of urgent referral – This is the post breach reallocation position, and includes 5.0 patients who breached 104 days (RCA undertaken.)
- 62 day upgrade – **local Target 85% - performance 54.5%** (3.5 out of 6.5 patients treated within 62 days of upgrade decision) – reasons as above.

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

- 2 week wait **– 95.16%** (177 out of 186 patients seen within 2 weeks)
- 31 days DDT – **94.74%** (18 out of 19 patients treated within 31 days of decision)
- 62 days – **58.33%** (3.5 out 6.0 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 – **81.82%** (4.5 out of 5.5 patients)

These are provisional figures and as has been seen in previous reports will change due to validation of information as part of the access target sign off process.

Overall, there is an improving trend with the cancer targets from the December indicators but still some concern with the 62 day target. There are still issues with delays with diagnostic testing MRI, CT, echo and pathology testing. The service is actively tracking patients and chasing results, however, capacity issues are restricting early diagnosis.

The clinical lead is reviewing clinical pathways and the service has accepted additional support from the cancer alliance to improve the wait to diagnosis. This will be a three month project.

3 NHSI intensive support team (NHSI IST)

The Trust invited the NHS IST to provide an expert assessment against the recovery plan and the IST sustainability tool that has been used to guide the recovery. This was a one day assessment was conducted in November and report back to the Executive team in December, 2018.

The IST team reported that it is clear that a significant amount of work has been undertaken within the organisation to improve situation in the short term, within the restrictions of the resources available (Access Centre leavers, consultant sickness/leavers, nurse leavers). This has been documented and monitored through a recognisable governance structure and has led to tangible outputs.
Long term RTT and Cancer recovery has been delayed due reduced clinical capacity, gaps in the nursing and operational structures and the reliance on interim roles latterly focused on stabilisation as opposed to informing the long term plan.

Notwithstanding the improvements made to date, The IST team observations demonstrate there is further work to be done and their report focuses on those areas for improvement in particular:-

- A long term action plan for the recovery and sustainability of RTT and Cancer targets
- Review of organisational structure and management capacity
- A demand and capacity review
- Review of clinical pathways
- Training strategy and plan of 18 weeks and cancer targets
- Escalation process for potential target breaches
- Data quality improvement plan

The Trust has negotiated additional expert support from the IST team and this is due to start on the 8th February, 2019.

The Trust has also commissioned an independent audit of both RTT and Cancer pathway waiting times. The audit looked at 802 RTT pathways and 173 Cancer pathways. The result of this audit provides significant assurance to the quality of the access target submissions:-

- RTT data was 95% accurate – rated as very good
- Cancer data 100% accurate – rated as excellent

This was the second independent audit of the 2018/19 and both providing assurance to the quality of the data submission.

4 Sickness

Sickness is currently 5% across the Trust compared with 4.28% for the same period, overall year on year the sickness figure for 2018/19 is 4.64% compared to 4.44% in 2017/18.

Maternity (increase in month 1.25%) and Gynaecology (decrease in month 0.84%) are both in excess of the 4.5% target and with the biggest staff groups drive the overall performance. There are 4 other smaller departments who are also over the 4.5% target and have contributed to an unusually spike in sickness for November and December.

Overall there was little change in the split between short term and long term sickness absence. The proportion changed from 34%/66% in month eight, to 37%/63% in month nine.

In terms of diagnoses, the top three remained unchanged with gastrointestinal problems as the most common, followed by anxiety/stress/depression and then cold/cough/flu.

Managers are continuing to work closely with their HR teams to ensure that individual cases are managed appropriately, that staff are managed on the appropriate stages and that staff are supported in returning to work as soon as is appropriate.

The Human Resources Department provide detailed absence information and advice to support managers in addressing sickness absence. They also provide training to new and existing managers in how to effectively manage sickness absence.

Support for managers is also provided by Occupational Health, particularly in terms of advice for supporting staff off long term in returning to work.

The Human Resources department are undertaking an ongoing project with NHSi to review sickness management across the Trust.

5 Conclusion

The RTT performance has stabilised at 87% and the backlog queues are also being maintained at around 600. More recent information in December and January is seeing the ASI list reducing as additional new capacity from locums is utilised. The service is currently revising RTT and Cancer recovery trajectories.

Cancer targets are showing signs of improving demonstrated by the provisional figures for December and this is supported by weekly provisional figures for January. Further work is required in reducing the waiting time to diagnosis.

The Trust has managed to secure additional expert support to work with teams in the Trust from the cancer alliance and the IST. A long term action plan is currently being produced in conjunction with the IST team.

The Sickness indicator highlights better than target performance between May and October but has unfortunately spiked to 5% in the last two months. The HR department and services managers are working collaboratively to reduce sickness absence.

6 Recommendation

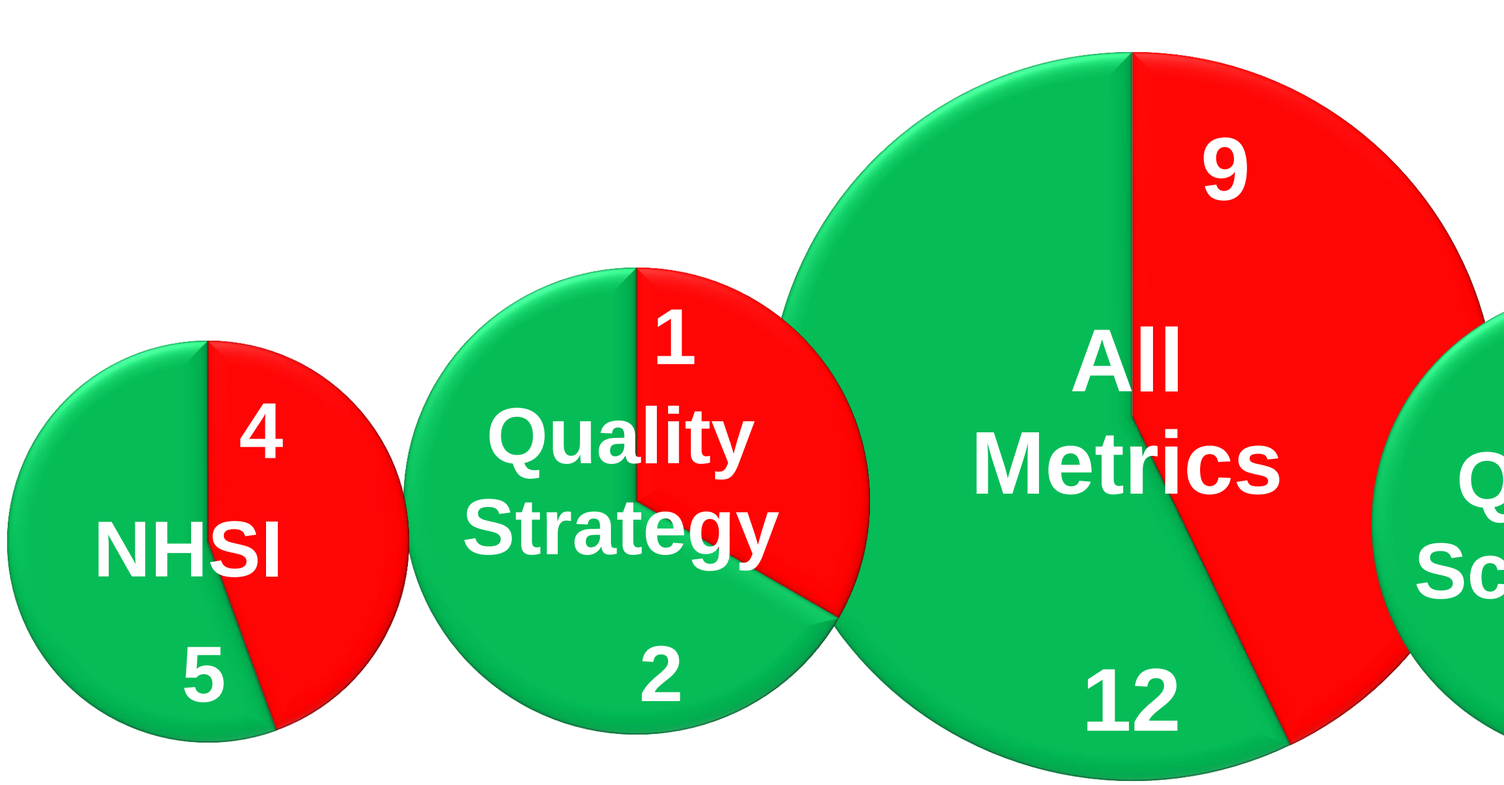
The committee is requested to note the contents of this report.

Appendix 1 – Scorecard

Performance and Information Department
Performance Team

Liverpool Women's NHS Foundation Trust

Performance Report for Trust Board — Month 09 - December 2018



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

Liverpool Women's NHS Foundation Trust

##

NHS Improvement 2018/19 Month 09 - December 2018

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	Deputy Director of Finance	3	3	3	3		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	1		0	1	0					
NHSE / NHSI Safety Alerts Outstanding	KPI193	Head of Governance	0	0	0	0		0	0	0		0	0	0					
Mortality Rates: Hospital Standardised Mortality Rates (HSMR) Gynaecology (1 Month Behind)	KPI321	Medical Director	Refer to qtrly Mortality report																
Mortality Rates: Summary Hospital Mortality Indicator (SHMI) (1 Month behind)	KPI322	Medical Director	Refer to qtrly Mortality report																

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

Indicator Name	Ref	Owner of KPI	Target	Apr-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%	4.2%		3.6%	5.0%	5.0%					

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%	86.45%	87.18%		87.10%	87.22%						
KPI003 Numerator				4137	4130	4238		4288	4312	4616		4522	4580						
KPI003 Denominator				4627	4636	4827		4888	4988	5295		5192	5251						
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%	30.77%	34.78%		45.45%	28.57%						
KPI1031 Final Numerator				5.0	4.0	10.5		8.5	2.0	4.0		5.0	3.0						
KPI1031 Final Denominator				9.5	11.5	16.5		16.5	6.5	11.5		11.0	10.5						
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%	28.57%	34.78%		37.04%	23.08%						
KPI1030 Final Numerator				5.0	4.0	10.5		12.5	2.0	4.0		5.0	3.0						
KPI1030 Final Denominator				9.5	12.0	18.5		20.5	7.0	11.5		13.5	13.0						
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	1	1		2	1						
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%	N/A	N/A		N/A	N/A						
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	2		8	5	7					

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%	4.2%	3.6%	5.0%	5.0%			
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	21	12	14	14				
A&E: Total Time Spent in A&E 95th percentile	KPI012 (KPI_62)	Head of Nursing	<= 240	230	235	225	225	236	229	238	217	229			
Friends & Family Test (Upper quartile will recommend)	KPI089	Head of Nursing	>= 75%	94.6%	96.4%	98.7%	96.9%	89.9%	97.4%	96.1%	98.4%	99.4%			

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%	4.23%	3.63%	4.97%	5.0%			

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	1	0	1	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	2	8	5	7			

Liverpool Women's NHS Foundation Trust

LWH Trust Objectives 2018/19 Month 09 - December 2018

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	Clinical Director Neonates	< 6.1%	0.0%	0.42%	0.28%	0.13%	0.00%	0.56%	0.28%	0.44%	0.14%			
Deaths (All Live Births within 28 Days) Booked births	KPI168	Clinical Director Neonates	< 4.6%	0.0%	0.28%	0.14%	0.13%	0.00%	0.42%	0.29%	0.45%	0.14%			

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	6	6	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	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	2	4.5	2	5				
18 Week RTT: Admitted	KPI001	Access Turnaround Manager	>= 90%	85.3%	90.6%	93.1%	93.0%	86.7%	86.7%	84.5%	80.9%				
KPI1001 Numerator				412	465	416	436	455	456	420	381				
KPI1001 Denominator				483	513	447	469	525	526	497	471				
18 Week RTT: Non-Admitted	KPI004	Access Turnaround Manager	>= 95%	91.0%	94.6%	91.9%	90.7%	81.2%	88.5%	90.3%	89.8%				
KPI1004 Numerator				1580	1684	1551	1742	1354	1450	1652	1817				
KPI1004 Denominator				1737	1781	1687	1921	1667	1639	1830	2023				

Agenda Item	2019/017

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	Finance Performance Review Month 9 2018/19
DATE OF MEETING:	Friday, 01 February 2019
ACTION REQUIRED	**For Discussion**
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 9 Financial Position.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee
	Date of meeting	21/01/2019

Executive Summary

The 2018/19 Board-approved budget set out a control total deficit of £1.6m for the year after the delivery of £3.7m 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 9 the Trust is reporting a year to date (YTD) deficit of £0.3m against a deficit budget of £2.4m, giving a year to date favourable variance of £2.1m. This is a sustained improvement on prior months. After careful and detailed review, the forecast has now been improved by £0.5m. It is assumed that this will lead to a further £0.5m of Provider Sustainability Fund income. 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	-£2.4m	-£0.3m	£2.1m	↑
Surplus/ (Deficit) FOT	-£1.6m	-£0.6m	£1.0m	↑
NHSI Rating	3	3	-	↔
Cash	£1.0m	£4.5m	£3.5m	↑
Total CIP Achievement YTD	£2.3m	£2.3m	£0	↔
Recurrent CIP Achievement YTD	£2.3m	£1.3m	-£1.0m	↓
Capital Spend YTD	£9.7m	£6.2m	-£3.5m	↑

[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.

The Month 9 financial submission to NHSI is consistent with the contents of this report.

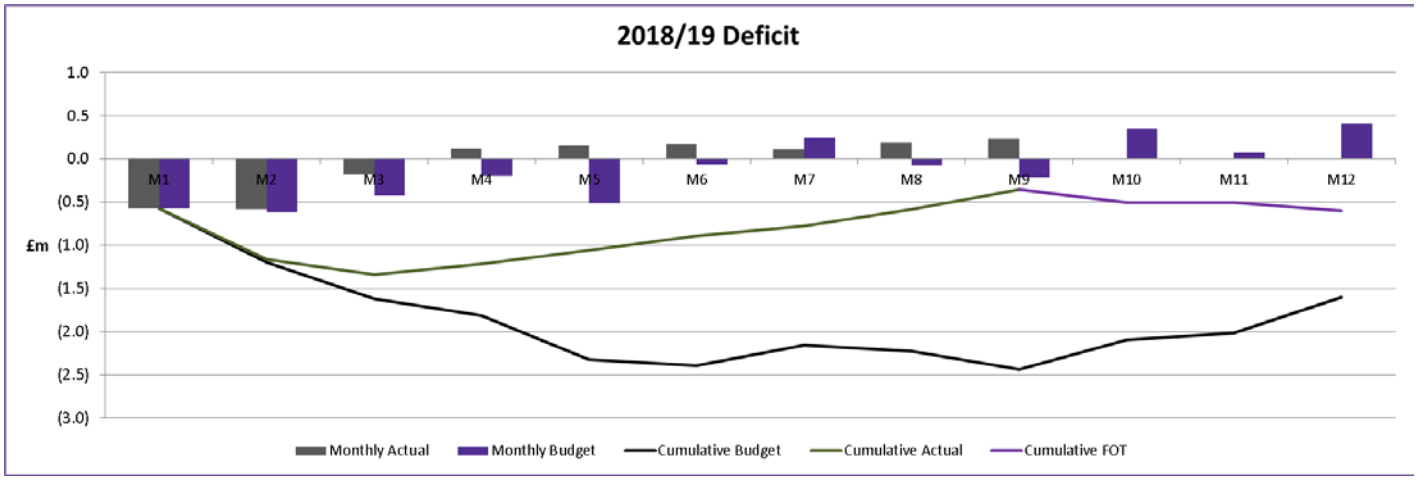
Report

1. Summary Financial Position

At Month 9 the Trust is reporting a deficit of £0.3m YTD against a deficit budget of £2.4m. The Trust is forecasting delivery of a revised £0.6m deficit for the full year, £1m ahead of the agreed control total as outlined below. The control total now assumes receipt of £4.1m PSF (including a £0.5m bonus).

	£m
Planned Deficit	(1.6)
Non-recurrent improvement	0.5
1:1 PSF awarded	0.5
Revised deficit forecast*	**(0.6)**

*This may be further improved by bonus PSF to be advised.



In 2018/19 the Trust continues to benefit from 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 £3.4m additional income earned YTD to Month 9, than would have been earned under PbR. This continued contract under-performance presents a significant financial risk to the Trust from 2019/20, and work is underway to address this, through the 'Right Size' programme and Operational Planning.

Although recurrent CIP programmes are behind plan, non-recurrent mitigations have been found and it is not anticipated that this under-delivery will impact the achievement of the control total.

2. Divisional Summary Overview

Key highlights of the divisional positions are noted below.

Division of Family Health: Maternity remains underspent in month and YTD and is expected to finish ahead of plan. Neonatal is within budget YTD and in-month but is expected to overspend in the full year

due to costs increasing through the Single Service (which is yet to be funded by NHS England) and additional costs of the Clinical Case for Change in the last months of the year. Overall, the Division is ahead of plan by £0.4m YTD but expected to be slightly underspent in the full year.

Division of Gynaecology: The Gynaecology directorate is overspent YTD by £0.5m, with both income and costs worse than plan. The run rate is anticipated to improve in the latter part of the year, as more substantive staff are recruited and activity increases.

The Hewitt Fertility Centre was also overspent in month again, primarily related to an over-spend on drugs and activity and income being behind target. The forecast has been revised downwards again to a contribution of £1.6m (against a plan of £3m).

Overall the division is overspent by £1.4m YTD and is forecast to be overspent by £1.5m in the full year.

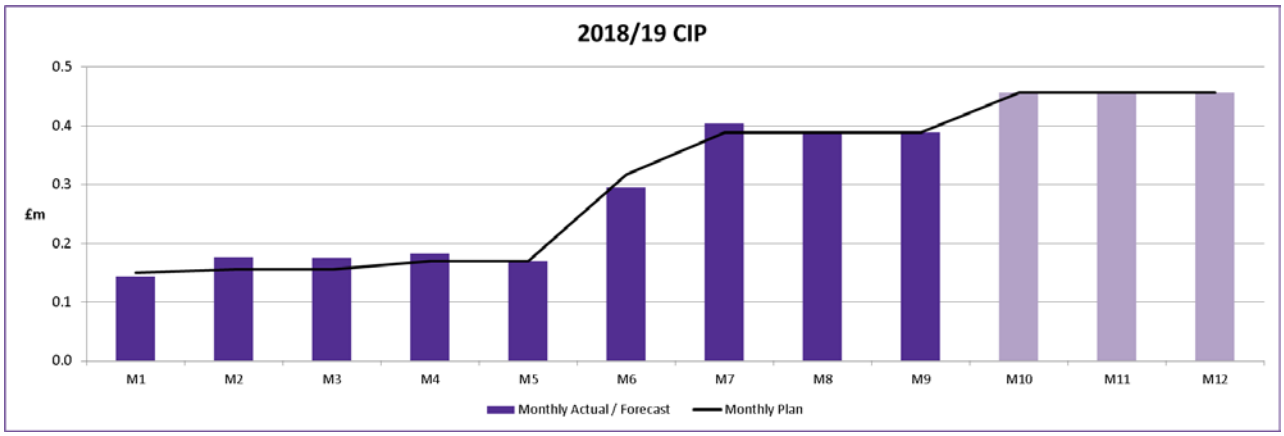
Division of Clinical Support: There is a continued underspend on both pay and non-pay YTD in Theatres, reflective of lower activity in both Gynaecology and Obstetrics. A marginal overspend in month leaves the Genetics directorate underspent by £0.1m overall YTD. Other areas are forecast to overspend due to continued overspends on agency, and the impact of the loss of the £1m of CNST Maternity Incentive.

Corporate Services and Technical Items: Overall these are ahead of plan in-month, YTD and in the forecast.

Agency: Expenditure against agency staff remains well within the limits set by NHSI, with £1.0m incurred to date against the £1.8m annual cap.

3. CIP

At Month 9 the Trust has delivered £0.4m against the in-month target of £0.4m, and is forecasting full delivery of the £3.7m CIP, albeit with significant non-recurrent elements (£2m in the full year forecast). The 2018/19 CIP has been profiled in line with planned delivery, which shows the target increasing throughout the year as follows. Underperformance on recurrent schemes has been offset by non-recurrent mitigations.



4. Contract Performance

Income YTD is £3.4m higher than would have been received under PbR.

Directorate	CCG	Month 9 Block	Month 9 Actual	Month 9 Variance	YTD Block Block	YTD Block Actual	YTD Block Variance
Maternity	Liverpool	2,387	2,250	(137)	22,443	21,401	(1,042)
Maternity	Knowsley	339	279	(60)	3,210	2,964	(246)
Maternity	South Sefton	568	502	(66)	5,337	4,883	(454)
Maternity	Southport & Formby	47	41	(6)	438	497	58
Maternity Total		**3,341**	**3,071**	**(269)**	**31,428**	**29,745**	**(1,683)**
Gynaecology	Liverpool	931	818	(112)	9,157	8,433	(724)
Gynaecology	Knowsley	201	155	(45)	1,978	1,601	(377)
Gynaecology	South Sefton	247	215	(32)	2,431	2,247	(184)
Gynaecology	Southport & Formby	36	23	(12)	346	287	(59)
Gynaecology Total		**1,414**	**1,211**	**(202)**	**13,911**	**12,568**	**(1,344)**
Hewitt	Liverpool	133	78	(54)	1,192	1,075	(117)
Hewitt	Knowsley	38	10	(28)	335	250	(85)
Hewitt	South Sefton	34	11	(23)	304	250	(54)
Hewitt	Southport & Formby	22	10	(13)	199	146	(53)
Hewitt Total		**227**	**109**	**(118)**	**2,029**	**1,721**	**(308)**
Other	Liverpool	9	4	(5)	97	77	(21)
Other	Knowsley	2	1	(2)	25	13	(12)
Other	South Sefton	3	2	(1)	27	19	(8)
Other	Southport & Formby	0	0	(0)	4	2	(2)
Other Total		**14**	**7**	**(7)**	**153**	**111**	**(42)**
Total		**4,996**	**4,399**	**(597)**	**47,522**	**44,144**	**(3,377)**

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. Action plans to address this through Operational Planning which will be reported through FPBD and Trust Board. Liverpool CCG, NHSE and the Cheshire and Mersey Health and Care Partnership are supportive of an Acting as One type arrangement going forward across the Cheshire and Mersey system. Initial activity plans have been submitted however the income attached to these is as yet unknown while national issues are finalised.

5. Forecast Out-turn

The forecast out-turn at month 9 has been improved by £1m, comprising £0.5m non-recurrent improvement and £0.5m assumed additional PSF.

6. Cash and Borrowings

The cash balance at the end of Month 9 was £4.5m 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 remain at £11.3m. A further £1m was drawn down in January relating to the Neonatal redevelopment, and a further £1.6m is expected to be drawn down in the rest of the financial year. This is part of an agreed £15m capital loan facility.

The Trust also expects to receive £1.6m in Public Dividend Capital in February relating to the Global Digital Exemplar (GDE) Fast Follower programme.

The Trust has a planned operational cash borrowing requirement of £1.6m for 2018/19 but the Trust is no longer forecasting any requirement for this facility.

7. Capital Expenditure

Of the total £12.5m capital plan, £6.2m has been spent YTD, primarily on GDE Fast Follower infrastructure and implementation costs. A total of £1.8m has now been spent YTD on the Neonatal Redevelopment. Following agreement of the Guaranteed Maximum Price (GMP), the forecast for this programme for 2018/19 has been revised to £3.9m (against an original plan of £7.3m). Loan drawdown has been revised accordingly. More detail is given in Appendix One.

8. Balance Sheet

Creditors are higher than at year end, primarily due to the Trust paying down creditors at year end and an expected increase in-year. A focus remains on recovery of debt, and debtors remain lower than the year end position and than plan.

9. BAF Risk

The BAF score for in year risk has been further reduced to 15 (a likelihood of 3 and impact of 5). This is due to sustained over-performance against plan over a number of months, and the crystallisation and management of a number of key risks

10. Conclusion & Recommendation

The Board is asked to note the Month 9 financial position.

Appendix 1 – Board Pack

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M9

YEAR ENDING 31 MARCH 2019

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M9
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	2,504	4,555	5,053	5,933
(b) PDC + Interest Payable + Loans Repaid	1,844	7,273	2,684	8,051
CSC Ratio = (a) / (b)	**1.36**	**0.63**	**1.88**	**0.74**
NHSI CSC SCORE	**3**	**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	(3,674)	(10,272)	(2,385)	(8,570)
(b) Expenditure	84,135	81,602	111,627	111,955
(c) Daily Expenditure	306	297	306	307
Liquidity Ratio = (a) / (c)	**(12.0)**	**(34.6)**	**(7.8)**	**(27.9)**
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)	2,437	329	1,601	1,601
Total Income	(86,621)	(86,116)	(116,656)	(117,837)
I&E Margin	**-2.8%**	**-0.4%**	**-1.4%**	**-1.4%**
NHSI I&E MARGIN SCORE	**4**	**3**	**4**	**4**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)				
I&E MARGIN VARIANCE FROM PLAN				
I&E Margin (Actual)		-0.40%		-1.40%
I&E Margin (Plan)		-2.80%		-1.40%
I&E Variance Margin	**0.00%**	**2.40%**	**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)%				
AGENCY SPEND				
YTD Providers Cap	1,353	1,353	1,805	1,805
YTD Agency Expenditure	963	756	1,284	1,307
	-28.8%	**-44.1%**	**-28.9%**	**-27.6%**
NHSI AGENCY SPEND SCORE	**1**	**1**	**1**	**1**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%				
Overall Use of Resources Risk Rating	**3**	**3**	**3**	**3**

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

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M9
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	(8,626)	(8,491)	(136)	(79,075)	(77,556)	(1,519)	(106,086)	(105,344)	(741)
Non-Clinical Income	(928)	(1,057)	128	(7,546)	(8,560)	1,014	(10,570)	(12,493)	1,923
Total Income	**(9,555)**	**(9,547)**	**(7)**	**(86,621)**	**(86,116)**	**(505)**	**(116,656)**	**(117,837)**	**1,181**
Expenditure									
Pay Costs	5,779	5,555	224	52,158	49,881	2,277	69,491	67,789	1,702
Non-Pay Costs	2,300	1,947	353	21,092	20,247	845	27,868	28,867	(999)
CNST	1,128	1,275	(147)	10,885	11,474	(589)	14,268	15,299	(1,031)
Total Expenditure	**9,207**	**8,777**	**429**	**84,135**	**81,602**	**2,533**	**111,627**	**111,955**	**(328)**
EBITDA	**(348)**	**(770)**	**422**	**(2,486)**	**(4,514)**	**2,027**	**(5,029)**	**(5,882)**	**853**
Technical Items									
Depreciation	389	393	(4)	3,406	3,520	(114)	4,586	4,695	(109)
Interest Payable	34	17	17	251	183	68	356	256	100
Interest Receivable	(2)	(4)	2	(18)	(41)	23	(24)	(51)	27
PDC Dividend	143	120	23	1,287	1,184	103	1,716	1,582	134
Profit / Loss on Disposal	0	8	(8)	0	0	0	0	0	0
Total Technical Items	**564**	**534**	**30**	**4,926**	**4,846**	**80**	**6,634**	**6,483**	**151**
(Surplus) / Deficit	**216**	**(236)**	**452**	**2,440**	**332**	**2,107**	**1,605**	**601**	**1,004**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
EXPENDITURE: M9
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	310	51	3,248	3,001	247	4,331	4,060	271
Medical	1,377	1,383	(6)	12,391	11,700	691	16,521	16,288	233
Nursing & Midwifery	2,469	2,397	72	22,364	21,459	905	29,768	28,771	997
Healthcare Assistants	390	368	23	3,519	3,449	70	4,690	4,673	17
Other Clinical	558	545	13	5,022	4,817	205	6,696	6,498	198
Admin Support	168	147	20	1,509	1,439	71	2,013	1,954	59
Corporate Services	349	323	26	3,141	3,019	122	4,187	4,106	81
Agency & Locum	107	83	24	964	997	(33)	1,285	1,439	(154)
Total Pay Costs	**5,779**	**5,555**	**224**	**52,158**	**49,881**	**2,277**	**69,491**	**67,789**	**1,702**
Non Pay Costs									
Clinical Suppplies	715	848	(132)	6,696	6,866	(170)	8,930	9,083	(153)
Non-Clinical Supplies	493	225	269	4,534	4,157	377	6,009	5,613	396
CNST	1,128	1,275	(147)	10,885	11,474	(589)	14,268	15,299	(1,031)
Premises & IT Costs	458	421	37	4,128	4,478	(350)	5,303	5,925	(621)
Service Contracts	633	454	179	5,734	4,746	988	7,626	8,246	(620)
Total Non-Pay Costs	**3,428**	**3,222**	**206**	**31,977**	**31,721**	**256**	**42,136**	**44,166**	**(2,030)**
Total Expenditure	**9,207**	**8,777**	**429**	**84,135**	**81,602**	**2,533**	**111,627**	**111,955**	**(328)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M9
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	(3,829)	(3,777)	(52)	(35,926)	(35,519)	(407)	(47,997)	(47,584)	(413)
Expenditure	1,794	1,738	57	16,193	15,481	712	21,591	20,928	664
Total Maternity	**(2,034)**	**(2,039)**	**5**	**(19,732)**	**(20,038)**	**306**	**(26,406)**	**(26,656)**	**250**
Neonatal									
Income	(1,360)	(1,411)	51	(12,295)	(12,242)	(53)	(16,388)	(16,267)	(120)
Expenditure	1,018	1,013	5	9,207	9,074	133	12,276	12,363	(87)
Total Neonatal	**(342)**	**(398)**	**56**	**(3,088)**	**(3,168)**	**80**	**(4,112)**	**(3,905)**	**(207)**
Division of Family Health - Total	**(2,377)**	**(2,437)**	**61**	**(22,820)**	**(23,206)**	**386**	**(30,518)**	**(30,561)**	**43**
Gynaecology									
Income	(2,003)	(1,906)	(97)	(19,479)	(19,091)	(388)	(26,139)	(26,383)	245
Expenditure	870	902	(32)	8,034	8,097	(63)	10,659	11,023	(364)
Total Gynaecology	**(1,132)**	**(1,003)**	**(129)**	**(11,445)**	**(10,994)**	**(451)**	**(15,480)**	**(15,361)**	**(119)**
Hewitt Centre									
Income	(756)	(706)	(51)	(7,767)	(7,062)	(704)	(10,555)	(9,602)	(953)
Expenditure	629	685	(56)	5,720	6,004	(283)	7,627	8,031	(404)
Total Hewitt Centre	**(128)**	**(21)**	**(107)**	**(2,047)**	**(1,059)**	**(988)**	**(2,928)**	**(1,570)**	**(1,357)**
Division of Gynaecology - Total	**(1,260)**	**(1,024)**	**(236)**	**(13,491)**	**(12,053)**	**(1,438)**	**(18,408)**	**(16,931)**	**(1,477)**
Theatres									
Income	(39)	(39)	0	(350)	(353)	3	(467)	(472)	5
Expenditure	666	667	(1)	6,067	5,793	274	8,088	7,875	213
Total Theatres	**627**	**628**	**(1)**	**5,717**	**5,440**	**277**	**7,621**	**7,403**	**218**
Genetics									
Income	(603)	(573)	(30)	(5,433)	(5,511)	78	(7,246)	(7,338)	92
Expenditure	473	469	4	4,260	4,215	45	5,680	5,681	(1)
Total Genetics	**(130)**	**(104)**	**(26)**	**(1,172)**	**(1,296)**	**123**	**(1,565)**	**(1,656)**	**91**
Other Clinical Support									
Income	(26)	(23)	(3)	(245)	(225)	(19)	(330)	(319)	(11)
Expenditure	733	711	21	6,789	6,966	(176)	8,987	9,221	(234)
Total Clinical Support & CNST	**707**	**689**	**18**	**6,545**	**6,741**	**(196)**	**8,657**	**8,902**	**(245)**
Division of Clinical Support - Total	**1,204**	**1,213**	**(9)**	**11,089**	**10,885**	**204**	**14,712**	**14,648**	**64**
Corporate & Trust Technical Items									
Income	(939)	(1,113)	175	(5,127)	(6,112)	985	(7,534)	(9,871)	2,337
Expenditure	3,587	3,126	461	32,790	30,818	1,971	43,353	43,317	36
Total Corporate	**2,648**	**2,013**	**636**	**27,662**	**24,706**	**2,956**	**35,819**	**33,446**	**2,373**
(Surplus) / Deficit	**216**	**(236)**	**452**	**2,440**	**332**	**2,107**	**1,605**	**601**	**1,004**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
CIP: M9
YEAR ENDING 31 MARCH 2019

SCHEME	MONTH 8			YTD			YEAR		
	TARGET	ACTUAL	VARIANCE	TARGET	ACTUAL	VARIANCE	TARGET	FOT	VARIANCE
Legal Premium Reduction	147	0	(147)	589	0	(589)	1,030	0	(1,030)
Patient Flow & Demand	16	9	(7)	47	18	(29)	95	47	(30)
Service Development Income	11	4	(7)	91	37	(54)	124	60	(56)
Service Development Non Pay	49	31	(18)	336	278	(57)	482	376	(104)
Service Development Pay	34	4	(29)	140	37	(102)	240	50	(191)
System & Environmental Income	7	6	(1)	53	51	(3)	73	69	(5)
System & Environmental Non Pay	20	26	5	86	131	45	147	152	4
Technology	26	26	0	233	227	(6)	515	309	(206)
Workforce	80	62	(18)	710	548	(162)	949	741	(202)
Non-recurrent Mitigation	0	222	222	0	998	998	0	1,853	1,821
TOTAL	**389**	**389**	**0**	**2,285**	**2,326**	**41**	**3,656**	**3,656**	**0**

*Scheme names as per NHSI return

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M9
YEAR ENDING 31 MARCH 2019

BALANCE SHEET £'000	YEAR TO DATE Opening	M09 Actual	Movement
Non Current Assets	**76,313**	**78,899**	2,586
Current Assets			
Cash	6,013	4,543	(1,470)
Debtors	8,407	7,533	(874)
Inventories	452	508	56
Total Current Assets	**14,872**	**12,584**	**(2,288)**
Liabilities			
Creditors due < 1 year	(11,257)	(17,522)	(6,265)
Creditors due > 1 year	(1,686)	(1,662)	24
Loans	(17,221)	(11,315)	5,906
Provisions	(4,514)	(4,809)	(295)
Total Liabilities	**(34,678)**	**(35,308)**	(630)
TOTAL ASSETS EMPLOYED	**56,507**	**56,175**	**(332)**
Taxpayers Equity			
PDC	38,451	38,451	0
Revaluation Reserve	15,367	15,367	0
Retained Earnings	2,689	2,357	(332)
TOTAL TAXPAYERS EQUITY	**56,507**	**56,175**	**(332)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M9
YEAR ENDING 31 MARCH 2019

CASHFLOW STATEMENT	YEAR TO DATE		
£'000	Budget	Actual	Variance
Cash flows from operating activities	(920)	(994)	74
Depreciation and amortisation	3,406	3,520	(114)
Movement in working capital	(3,273)	9,067	(12,340)
Net cash generated from / (used in) operations	**(787)**	**11,593**	**(12,380)**
Interest received	18	41	(23)
Purchase of property, plant and equipment and intangible assets	(9,755)	(6,184)	(3,571)
Proceeds from sales of property, plant and equipment and intangible assets	0	0	0
Net cash generated from/(used in) investing activities	**(9,737)**	**(6,143)**	**(3,594)**
PDC Capital Programme Funding - received	1,600	0	1,600
Loans from Department of Health Capital - received	4,100	0	4,100
Loans from Department of Health Capital - repaid	(306)	(306)	0
Loans from Department of Health Revenue - received	1,127	0	1,127
Loans from Department of Health Revenue - repaid	0	(5,600)	5,600
Interest paid	(152)	(183)	31
PDC dividend (paid)/refunded	(858)	(831)	(27)
Net cash generated from/(used in) financing activities	**5,511**	**(6,920)**	**12,431**
Increase/(decrease) in cash and cash equivalents	**(5,013)**	**(1,470)**	**(3,543)**
Cash and cash equivalents at start of period	6,013	6,013	0
Cash and cash equivalents at end of period	**1,000**	**4,543**	**(3,543)**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding at M09
Loans from Department of Health Capital (ITFF)- 2.0% Interest Rate	5,500	(1,835)	3,665
Loans from Department of Health Capital (Neonatal)- 2.54% Interest Rate	1,000	0	1,000
Loans from Department of Health Revenue - 1.50% Interest Rate	14,612	(7,962)	6,650
Total	**21,112**	**(9,797)**	**11,315**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M9
YEAR ENDING 31 MARCH 2019

CAPITAL EXPENDITURE

£'000	Full Year Budget	YTD Budget	Year to Date Actual	Residual Capital Budget	YTD Variance
Neonatal New Building	6,968	5,068	1,755	5,213	3,313
Other Building Projetcs	293	243	13	280	230
Estates & Environmental Projects	441	412	204	237	208
Global Digital Examplar Fast Follower Technology	2,800	2,100	2,818	(18)	(718)
Information Management & Technology (IM&T) Projects	400	300	399	1	(99)
Medical Equipment	1,418	1,396	948	470	448
Other	222	222	18	204	204
Total	**12,542**	**9,741**	**6,155**	**6,387**	**3,586**

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	2019/019

MEETING	**Trust Board**	
PAPER/REPORT TITLE:	**Board Assurance Framework**	
DATE OF MEETING:	Friday, 01 February 2019	
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:-….)***	1. Note the assurance presented re process and proposal(s) within this report. 2. Advise the Governance team of approval /views in respect of the process, proposals and rationale.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Sub Committees of the Board
	Date of meeting	During November 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 risks on the BAF are set out against the Trust's 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 is being reasonably managed.
- Board reports detailing how risk is 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 Trust's Head of Governance and Quality meets with each of the Executive Director leads on a monthly basis to ensure the BAF is maintained as a live document and is aligned with the Trusts corporate risks.

Each of the Board committees (Finance, Performance and Business Development, Quality Committee and Putting People First Committee) continue to have the responsibility to review and gain assurance to controls and actions required and to make recommendations to the Board on any amendments to the Risk or risk score.

Report

1. Introduction

This report seeks to assure and inform the Board of the process and outcomes from Board and Board Committee review of risks assigned to the Board Assurance Framework. Any changes in risk score or escalation / de-escalation proposals made by Board 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 attached for January 2019, following review by each of the Board Committees.

2. Sub-Committee Changes to Risks

Since the last report to the Board, the Board Committees have reviewed the risks within their remit and proposed the following amendments:

BAF Risk Condition - Potential for poorly delivered positive experience for those engaging with our services**:**

- *Removed from Gaps In Assurance:*
  - Removal of statutory supervision with no agreed model in place for MW
  - Nurses and AHP's supervision needs development and implementation
  - Telephone line services for booking and advice in GED and MAU
- *Added to Controls:*
  - All patient leaflets are electronic with translation available.
  - New supervision policy for Nurses, MW and AHPs' agreed
- *Completed Actions:*
  - 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)

BAF Risk Condition: Failure to deliver the annual financial plan (2018/19)

- *Current Risk Score*
  - Current likelihood reduced from 4 to 3 therefore reducing the current overall score from 20 to 15.

3. New Risks and Closed Risk

Since the last report (1 December 2018) 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 Executive Lead and Board Committees and resulting changes to risk scores, mitigation and supporting corporate and service risks are in accordance with the review and escalation and de-escalation processes.

The Board are asked to:

1. Note the assurance presented re process and proposal(s) within this report.
2. Approve the amendments recommended by the Board Committees; and
3. Report back, through the Trust Secretary, any amendments to the BAF arising from the discussion at the Board meeting.

2018/19 Live Board Assurance Framework – January 2019 – Version 5

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, 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 • 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 • Whistleblowing Policy • Guardian of Safe Working • Engagement tool implemented • People Strategy revised and agreed	• 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 • 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** • None at this time	• PPF deep dive into service workforce risks • Aspirant Managers programme being rolled out • Executive Team and staff side walkabouts • Launch of Fair and Just Culture Project	• Monthly monitoring • Monthly monitoring 2019 • Monthly monitoring 2019 • Feb 19 (revised date)
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 • 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. • 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	• 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) with Lead Employer validates Jr Dr work plans • Junior Medical Staff – annual internal staff survey • Annual GMC Survey • Strategic Workforce reporting to PPF	**Assurance Outcomes** • New Exception Reporting system and process working effectively. • Junior Medical Staff GMC survey reporting to Education Governance & PPF – no areas of specific concern identified	• 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 for recruitment of Drs from India for Gynaecology • Operational Plan for increased number of consultants	• Monthly monitoring • Monthly monitoring • Monthly Monitoring
			Metrics • Exception reporting data • Monitoring exercise data • Absence data from Lead Employer • Whistleblowing reports	**Assurance Gaps** • None Identified		

	Risks from Risk Register • 2 x Corporate Risks • 9 x Service Risks	Hours. • Junior Doctor Forum held quarterly for concerns to be raised. • Remediation Policy. • Monitoring exercises undertaken on annual basis to ensure compliance on junior doctor rotas • Acting-down policy and process in place to cover junior doctor gaps • National Medical Revalidation process ensuring competent doctors • Annual Workforce Planning exercise with operational and clinical teams • Shared decision making and review of risks with Joint Local Negotiating Committee • Putting People First Strategy • Quality Strategy 2017-2020 • Strategic Workforce Group established • Advanced and Enhanced nursing and midwifery roles • GMC Survey 2018 action plan in place		**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	• April 2019 (subject to approval of wave 4 STP capital bid in December 2018) • July 2019 (subject to approval of wave 4 STP capital bid in December 2018) • December 2019 (subject to approval of wave 4 STP capital bid in December 2018) • TBC –requirement to be confirmed subject to outcome of STP bid • April 2021 (subject to NHSI approval) • April 2020 - 2025
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 • Control of expenditure through actively monitoring spends • Holding of discretionary spend areas (i.e. Transformation Team).	• 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) •Sustained performance above plan	**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**	Reduced to 3 from 4	5	**Reduced to 15 from 20**	2	5	**10**

Strategic Objective: To deliver **safe** services

Risk Appetite: LOW

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

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 **Risks from Risk Register** • 12 x Corporate Risks	• 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 • Failure to meet RCOA Standards for Care of Women Critically Ill and Women in Childbirth, August 2018.	• 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)

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 **Risks from Risk Register** • 3 x Corporate Risks • 11 x Service Risks	• 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 from 2018 visit Safe as 'Good' across all areas of the Trust	• Fair and Just culture Project • Maintain close involvement with regional and local safety collaborative	• Feb 19 • Monthly monitoring (revised 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	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	• Regular review of compliance position • Provide assurance to CQC in relation to risks with appropriate information.	• 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 (Electronic Patient Record)

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 UK Market • 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 • Clinician engagement undertaken **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 available benchmarking data due to nature of specialist services provide • 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 February 2019 (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.	• 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 • All patient leaflet electronic with translation available. • New supervision policy for Nurses, MW and AHPs' agreed	• 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)	**Gaps** • Out of date policies • Telephone line services for booking and advice in GED and MAU • Insufficient quality of interpretation services	• Policies Group to continue monitoring and working to reduce Out of date levels. • ~~Consider how to enhance assurance levels around the involvement of hard to reach groups.~~ • Ensure patient access and message system in place. • Review current service and commission replacement if required • ~~Respond to the findings of the CQC's national surveys (Maternity / Inpatient)~~	• Ongoing • ~~February 2019 (revised date)~~ • March 2019 • Review completed Jan 2019. Commissioning of new service due to commence 1st March 2019. • ~~Ongoing (revised form specific date)~~ **Completed, action plan in place**
Risks from Risk Register • 2 x Corporate Risk • 13 x Service Risks			**Metrics** • Complaints data • PALS data • FFT Results • Staff survey engagement score • Vacancy / turnover levels • Safe staffing levels **Independent / semi-independent** • National Maternity Survey • National Inpatients Survey • Regulatory inspection	**Outcomes** • Staff survey results awaited		

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