Meeting of the Board of Directors
HELD IN PUBLIC
Thursday 2 May 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
063	Apologies for absence Declarations of interest	Receive apologies	Verbal	Chair		-
064	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written	Chair		Well Led
065	Patient Story	To receive a patients story	Presentation	Gynaecology	0940 (20mins)	Safe, Experience, Well led
066	Minutes of the previous meeting held on 4 April 2019	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1000 (5mins)	Well Led
067	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair		Well Led
068	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1005 (10mins)	Well Led
069	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive		Well Led

Item no. 2019/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
BOARD COMMITTEE ASSURANCE						
070	Chair's Report from Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1015 (15mins)	Well Led
071	Chair's Report from Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair		Safe Well Led
072	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						
073	Liverpool Health Partners- Trust's participation 'Starting Well'	For assurance	Presentation	Colin Morgan Consultant Neonatologist	1030 (20mins)	Safe Well Led
074	Guardian of Safe working – Annual report 2018/19	For assurance	Written	Medical Director/ Guardian of Safe Working	1050 (10mins)	Well Led, caring
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES						
075	i) Safer Nurse/Midwife Staffing Monthly Report period M12 2018/19 ii) Review of Headroom Percentage and Birth Rate Plus	For assurance and to note any escalated risks	Written	Director of Nursing and Midwifery	1100 (15mins)	Well Led, caring, Safe
076	Operational Performance Report period M12, 2018/19	For assurance –To note the latest performance measures	Written	Interim Director of Operations	1115 (10mins)	Well Led
077	Finance Report period M12, 2018/19	For assurance - To note the current status of the Trusts financial position	Written	Director of Finance	1125 (10mins)	Well Led
TRUST STRATEGY						
078	Future Generations – Clinical Sustainability of Services	For noting.	Verbal	Chief Executive	1135 (10mins)	Well Led

Item no. 2019/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
079	Corporate Objectives 2018/19 outturn and Corporate Objectives 2019/20	For approval	Written	Chief Executive	1145 (10mins)	Well Led
BOARD GOVERNANCE						
080	NHS Improvement compliance: Provider Licence General Condition 6 and Continuity of Services 7	For Approval	Written	Trust Secretary	1155 (10mins)	
081	Risk Appetite Statement 2019/20	For Approval	Written	Trust Secretary	1205 (05mins)	
082	Board Assurance Framework • 2018/19 • 2019/20	For assurance and approval	Written	Trust Secretary	1210 (10mins)	Well Led
083	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1220 (10mins)	Well Led
HOUSEKEEPING						
084	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1230 Meeting ends	Well Led

Date of next meeting

Board Workshop: 6 June 2019

Board in Public: 4 July 2019

Meeting to end at 1230

1230-1240	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 2019

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. At all times the members should be cognisant of the meetings Terms of Reference.

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 for issue 7 days before the meeting (see bullet 2 below under Standards and Obligations)
- 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. Please check Terms of Reference of the Committee on each committees requirement.

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 should be issued 7 days before the meeting. Any changes to this timeframe require the agreement of the Chair of the meeting.
3. The draft minutes, Chair's Report and action schedule will be prepared and circulated to all members of the meeting within 7 days following the meeting.
4. Chair and members are also responsible for the committee/ subcommittee's compliance with relevant legislation and Trust policies
5. It is essential that meetings are chaired with an open and engaging ethos, where challenge is respectful but welcomed
6. 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
7. 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 members of the committee.
8. 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
9. 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 Secretary
10. 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 escalating the concern to their line manager or if this is not appropriate to the Trust Secretary or via the Trusts raising concerns policy
11. 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 raising concerns 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
12. 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, following 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

Board of Directors

Minutes of the meeting of the Board of Directors
held in public on 4 April 2019
at Liverpool Women's NHS Foundation Trust, Crown Street Liverpool.

PRESENT

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

IN ATTENDANCE

Mr Colin Reid	Trust Secretary

APOLOGIES:

Mr Tony Okotie	Non-Executive Director/SID
Dr Devender Roberts	Acting Medical Director
Mrs Tracy Ellery	Non-Executive Director
Prof Louise Kenny	Non-Executive Director

2019

The Chair opened the meeting and explained the reasons for the clothing attire of Board members. He advised that as part of the new charitable appeal for the Neonatal Unit 'The Big Tiny Steps Appeal' one of the ways of supporting the appeal was to wear 'Neon for Neo' and donate to the charity. The Chair advised that he had challenged the Board at the launch of the appeal to wear something neon for the appeal.

Thank You

Finance teams -David Dodgson and Samantha Wright: The Director of Finance provided the Board thank you to the Finance team on a successful and challenging system upgrade of the Finance Ledger. She advised that the team headed by David Dodgson had managed the supplier, IT and other stakeholders, ensuring the smooth transition. The Director of Finance referred to David Dodgson's contribution and explained that throughout a sometimes very difficult process, David had been calm, measured and focussed on finding solutions; communicating with everyone effectively, and dealt with issues as they arose.

The Director of Finance advised that the team had worked together to support this difficult transition successfully and with a positive, solution focussed attitude, despite this coming on top of busy day to day jobs and at a busy time of year. She advised that this had also been recognised at FPBD and Audit Committee.

033 **Apologies** – as above.
Declaration of Interests – None
Welcome: The Chair opened the meeting and welcomed everyone present.

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

035 **Patient Story Presentation – Home Birth Service**
The Patient Story was provided by Amy Kelly, Community Midwife and Susan Roberts, Matron for Community Midwifery. Amy Kelly advised the Board that as part of the National Maternity review all trusts providing midwifery care were required to implement models of midwifery care which promote relationship Continuity of Carer (CoC) in case-loading models or team case-loading models. She explained that the 'Midwife at Home Team' comprised of six dedicated midwives passionate about home birth; the team providing midwifery care throughout the pregnancy journey to low-risk women who were considering giving birth at home. The team provides a 24-hour service, seven days a week giving women access to a known midwife throughout pregnancy, birth and after their baby is born.

Amy Kelly advised that CoC provided by the team makes it easy for women to develop relationships with the midwives over the course of their pregnancy and that the care was determined by women's individual needs and circumstances, even down to location of appointments. Amy Kelly advised that this was the first official homebirth the Home Births Service team had and from the outset, continuity makes all the difference to mums-to-be.

Amy Kelly read out the patient's story and advised that the patient had self-referred to the Trust Home Birth Service due to the lack of continuity of care she was being provided and that her local trust was unable to provide a birth pool for labour at home.

Amy Kelly advised that the story went a long way to show how important it was for mums-to-be to have CoC in developing relationship continuity with the midwife. She went on to explain that having CoC supported the delivery of patient choices and personalised care which ultimately allowed for the birth to take place in accordance with the mum-to-be wishes; not only empowering mum-to-be but also providing an overall positive birth experience for the mum-to-be and the team.

Susan Roberts advised that the team had tested the case-loading model in order to demonstrate the benefits of CoC and to promote more births at home by providing women with evidence based information on the most appropriate and safest place of birth. She further advised that additional developments to promote the benefits of CoC includes staff and patient engagement, staff training days and the development of a CoC steering group which would ensure implementation of CoC models of care were at the forefront of the midwifery agenda.

The Chief Executive thanked Amy Kelly and Susan Roberts for a very positive patient story noting the positive experience both the patient and the team had. She was reassured that the Trust was offering all birthing options to the women the Trust serves, given the requirements of the National Midwifery Review.

Referring to the anticipated Board report on the National Maternity Review, the Chief Executive advised that she had requested from the Head of Midwifery a balanced report providing feedback received from women receiving the care through CoC and the positives and negatives of the provision of the service to staff. The Chair noted the comments around the empowerment of staff to manage their own workload which he saw as a very positive outcome. He was not certain of the percentage number of women who want home births and whether they change their minds or

unable to have a home birth due to complications. The Chair recognised however that resourcing would need to be assessed should there be a steep increase in the number of women wanting home births. Susan Roberts advised that there was no additional resource provided to the Trust in the implementation of CoC and advised that the national view was that it was 'just' a re-organisation of the way the service could be provided. Amy Roberts advised that the Trust was ahead of the game in terms of the setting up of the Midwifery at Home Team and CoC.

Susan Milner supported the provision of CoC and commented that once the word gets out, she was in no doubt that Mum-to-be would want to use the service and echoed the concern of the Chair that resource may not be available to support and upturn in demand. Ian Knight commented on the positivity he felt from the presentation and from the presenters in the delivery of the service. He felt it was a great advert for the team and the service.

The Chair asked the presenters whether there was one lesson that had been learnt in the implementation of the Midwifery at home and home birth service that could be shared across the Trust. Amy Kelly advised that having a small team of eight meant that there was constant communications between team members and the mum-to-be so that everyone was aware of the mum-to-be requirements, Susan Roberts commented that this communication created a great sense of being part of a team and more coordinated team working.

The Chair thanked Amy Kelly and Susan Roberts for their presentation and asked that they pass on the thanks of the Board to the Patient and the rest of the team.

036 **Minutes of previous meeting held on 1 February 2019**

The minutes of the board meeting held on 1 February 2019 were approved.

037 **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 Chair advised that a reference was made in the minutes to his meeting with Ian Dalton and reported that since his meeting, Ian Dalton had left NHS Improvement and therefore the meeting would not take place. He reported that arrangements were being made for a meeting with Bill McCarthy, the recently appointed NHS Improvement North West Regional Director.

038 **Chair's Announcements**

The Chair reported on the following matters:

The Big Tiny Steps Appeal: The Chair reported on the launch of The Big Tiny Steps Appeal that took place on Saturday 30 March 2019. He advised that there was a great turn out from families, staff and stakeholders. He advised that the appeal pledges to raise £250,000 to introduce essential family facilities to make the new Neonatal Unit a truly first class environment when it opens in 2020. The Chair thanked, in particular the families who continue to support events for the Unit and the staff who organised the successful event.

Appointment of Non-Executive Directors: the Chair reported on the Council of Governors appointment of Tracy Ellery and Professor Louise Kenny to the Board as non-executive directors from 1 March 2019. He advised that they, respectively, bring recent and relevant financial experience and clinical experience to the Board.

The Board noted the Chair's verbal update.

039 **Chief Executive's report**

The Chief Executive and Executive team commented on the following:

Neonatal Capital Program Build Project: The Director of Finance referred to the paper and reported on Interserve plc's administration and restructuring of the group. She advised that the work was continuing on the build and that it was business as usual. The Director of Finance advised that the Trust would continue to keep a watching brief on the supplier position.

Data Quality: The Chief Executive referred to the paragraph she had included in the report relating to the Board workshop where the Board had received assurances with regards to data quality following the two SIs reported in 2018. The Board noted the paragraph that reflected the discussion at the workshop.

Liverpool Health Partners (LHP): The Chief Executive advised on the work being undertaken in support of LHP. She advised on the three research themes and reported that Colin Morgan, Consultant Neonatologist would be providing support to LHP for their 'starting well' theme. The Chief Executive advised that this was a positive step in making sure that the Trust was linking into and committed to the programmes within Liverpool. She advised that Colin Morgan had been asked to come to a future Board meeting to present the work he was undertaking.

OCS staff industrial Dispute: The Director of Workforce and Marketing reported that the unions representing OCS staff and OCS had reached an agreement regarding the dispute and industrial action that had impacted on the services OCS provided to the Trust. She advised that as a consequence there would be no further action taken by OCS staff.

Making Every Contact Count (MECC): The Board noted the initiative being implemented within the Trust that enables staff to be proactive in facilitating greater awareness to patients and service users of health and wellbeing initiatives.

HCW flu vaccination information: The Director of Workforce and Marketing referred to the report and noted that a lot of the information provided had been reported previously to the Board and Putting People First Committee. The Board noted the assurance surrounding the flu vaccination campaign and the effective execution of the plan.

The Chair thanked the Chief Executive for presenting her Report, which was noted.

040 **Chair's Report from Quality Committee (QC)**

Susan Milner presented the Chair Report from the Quality Committee meetings held on 18 March 2019 and advised that the Committee had received assurance from each of its sub-committees/senates on the work they had been carrying out.

Referring to the Board Assurance Framework (BAF), Susan Milner advised that the Committee had reviewed the Quality related BAF risks and had agreed the amendments that have been reported in the Board Assurance Framework agenda item later in the meeting. She advised that the Committee had received assurance that the risks attributable to the Committee were being managed appropriately, however the Committee had recommended that each risk needed to be reviewed in light of the current year end to ascertain whether the risks continued to be relevant and that the risk scores were to be assessed against the Trust's agreed risk appetite statement for 2019/20. The Chair noted the comment and understood that this would be carried out for all risks on the BAF.

Susan Milner referred to the risk appetite statements discussed for the areas of accountability the Committee had agreed that for the corporate objective to deliver safe services and to deliver the best possible experience for patients and staff the risk appetite should remain 'low'; however with regards to participate in high quality research and to deliver the most effective outcomes effective

outcomes, the Committee felt that the Trust should change the appetite to 'high' to be consistent with the aspirations of the Trust with regards to Research and Development.

Referring to the CQC action plan, Susan Milner advised that the Committee had received assurance on the progress being made against it, in particular the verbal assurance regarding the recent MIAA spot checks with regards to Gynaecology and Bedford. She advised that there was some very positive outcomes with regards to Gynaecology were positive feedback was provided by staff following the introduction of the new leadership team. With regards to the regulation 10 breach, the Director of Nursing and Midwifery reported that the 'door' to the admission room had now been installed.

Susan Milner reported on the partial assurance the Committee had received in relation to the implementation of LocSSIPs (Local Safety Standards for Invasive Procedures) to the necessary standards required by commissioners. She explained that the Committee had asked for a full report within the next few months to provide the required full assurance that the LocSSIPs were fully embedded.

Susan Milner referred to the review of the Quality Committee Terms of Reference and Business Cycle which were approved by the Committee; and the review of Corporate Objectives Outturn 2018/19 and Corporate Objectives 2019/20 in relation to Quality Committee Responsibility which were also approved by the Committee and would require Board approval.

The Chair noted each of the items requiring Board approval and commented that at it would only be appropriate to approve the first two items at this meeting leaving the Corporate Objectives and Risk Appetite approvals to the Meeting on 2 May 2019, following receipt of the output from the Putting People First Committee.

The Board approved the amendments to the Terms of Reference of the Committee and agreed to seek approval of the changes to the BAF under agenda item 2019/050.

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

041 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 25 March 2019.

Referring to the Finance Performance Review Month 11 2018/19 Jo Moore advised that the Committee were assured that the Trust was on target to deliver an improved deficit for the year; this was however partly due to the benefit of the Acting as One contract with Liverpool CCG which meant the block payment was higher than would have been earned by Payment by Results. With regards to the Operational Performance Month 11 2018/19 the Committee received assurance on the actions being taken to address underperformance in RTT and Cancer targets. She noted that both the Finance Report and Operations Report who be discussed further later in the meeting.

Jo Moore reported on the Committees' receipt of the Revenue and Capital Budget 2019/20 and the Operational Plan 2019/20 and reported that the Committee was assured that the Trust was able to agree a 2019/20 Plan that delivered a break-even control total set by NHSI. She advised that there were some considerable risks in delivery of the Plan; however after full and frank discussion the Plan was approved for recommendation to the Board, subject to the agreement of contracts with commissioners. The Chair reported that the Plan had been approved by the Board out of meeting in time to meet the NHSI submission deadlines.

Jo Moore reported on the presentation from the Chief Information Officer with regards to the

progress of the EPR project. She advised that the Committee continued to be concerned that progress was not being made and what the impact would be on the Trust. Jo Moore reminded the Board that the Committee had escalated its concerns following the meeting.

Referring to the Single Neonatal Service, Phil Huggon asked whether there were any concerns regarding progress to date. The Board noted that there were some areas that still needed to be finalised as part of the management of the service and these were being addressed with Alder Hey.

Jo Moore advised that the Committee had reviewed the BAF risks and agreed changes to the current risk level for the "delivery of the annual plan 2018/19" noting that the risk score should be reduced to 10 given that the Trust was on target to deliver the annual plan 2018/19. Jo Moore reported on the changes to BAF risk 2184 'electronic patient record' which was referred to in the report later in the meeting. The Committee had reviewed the Risk Appetite statement that related to the Committees areas of responsibility and had agreed that the risk appetite remained 'moderate'. With regards to the Corporate Objectives Outturn 2018/19 and Corporate Objectives 2019/20, Jo Moore reported on the Committees approval of both the Corporate Objectives Outturn 2018/19 and Corporate Objectives 2019/20 in relation its areas of responsibility and noted that that these two items plus the Risk Appetite statement would be taken to the Board at its meeting on 2 May 2019.

Jo Moore advised that the Committee had also reviewed its Terms of Reference and Business Cycle 2019/20 which were approved; the Terms of reference were now submitted to the Board for approval. The Board approved the FPBD Terms of Reference.

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

042 **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 25 March 2019. In particular Ian Knight highlighted the work of the Committee with regards to the assurances arising from the work of MIAA 2018/19; the draft the Head of Internal Audit year-end opinion that would be reported through the Trust's Annual Governance Statement; the Internal Audit plan 2019/20. He also referred to the three reports received from Counter Fraud, the 2018/19 progress report, draft annual report 2018/19 and the Counter Fraud work plan 2019/20, noting the assurance received.

Ian Knight referred to the report from the External Audit Director, Tim Cutler on progress made to date. Referring to areas of judgement in the Annual Accounts, Ian Knight advised that the Committee was assured that the Trust was addressing the areas correctly and approved the approach that the accounts should be prepared on a going concern basis.

With regards to the external assurance received from the 'Waiting Times External Audit December 2018', Ian Knight advised that the audit showed that data issues regarding national submissions identified in the two SIs declared early in 2018 had been addressed and rectified. This was also reported to the Board at its March workshop.

Ian Knight advised that the Committee was assured that the procedures and processes were in place for staff to raise concerns noting the commitment of the Trust to developing and maintaining an open and transparent culture.

Ian Knight informed the Board of the changes approved by the Committee to the Trust's Risk Management Strategy noting that the Strategy had also been received and approved by the Quality Committee. He reported that the Committee had received assurance from the MIAA Internal Audit review of the risk management process during 2018/19 which had provided substantial assurance

that the core control mechanisms were in place to manage the risk management process.

Referring to the Audit Committee Effectiveness and Review Output, Ian Knight reported that actions to be taken following the review would be addressed across all the committees. The Chair advised he was seeking to put together a small group comprising of NEDs, Executive and Trust Secretary to look at how the Committees report assurance to the Board, this group would report back to the Board at the June workshop.

Ian Knight advised on the changes made to the Committee Terms of Reference and Business Cycle. He advised that the Terms of Reference are submitted to the Board for approval. The Board approved the Terms of Reference of the Committee.

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

043 Annual Staff Survey

The Director of Workforce and Marketing presented the findings of the Annual Staff Survey undertaken in 2018; the results being published in March 2019.

The Director of Workforce and Marketing reported that the Survey showed no significant changes compared to the 2018 results; most notable was that the key "Engagement" score had remained stable. She explained that this was in line with the "Engagement" score at a national level which also remained static. The Director of Workforce and Marketing advised that this was a disappointment given the amount of work and engagement the Trust had undertaken over the year; however may reflect the low morale particularly in Gynaecology at the time the Survey was undertaken.

The Director of Workforce and Marketing advised that there were no real significant surprises for the Trust and reported that the newly agreed Putting People First Strategy sought to address the shortcomings. The Director of Workforce and Marketing referred to the work being undertaken in the implementation of the Fair and Just Culture which would also seek to address areas of concern arising from the Survey. In response to a question from Ian Knight regarding the timeframe for the embedding of the Fair and Just Culture, the Director of Workforce and Marketing reported that it was coming to the end of its first year of a five year program and provided an update on progress.

Concern was expressed regarding the poor survey results regarding: safety culture; recommendation of place to work; and quality of care and expressed a need to address these areas. The Director of Workforce and Marketing advised that when discussing these areas with staff the perception was different and felt that with the introduction of the new Divisional structure it was hoped that each Division would take greater ownership of the their people plans and be held accountable for delivery.

The Board received the content of the Annual Staff Survey 2018 report, noting that progress against the action plans would be taken though the Putting People First Committee.

044 Feedback from the Nursing and Midwifery Listening Event

The Director of Nursing and Midwifery presented the feedback from the Nursing and Midwifery Listening Event reminding the Board that the event coincided with the launch of staff engagement in developing the Nursing, Midwifery and AHP strategy. The Director of Nursing and Midwifery advised that the interactive nature of the Listening Event provided an excellent forum to engage and to garner information.

The Director of Nursing and Midwifery advised that the responses were collated and reviewed and

had been used with other extensive engagement sessions in the initial development stages of the Strategy. She reported that the Strategy must fit with existing strategies and values and behaviours already in place such as the Putting People First Strategy and a first draft of the Strategy would be available in time for Midwives, Nurses and AHP day in May 2019; anticipating that the strategy would be launched in the autumn 2019.

The Board supported the process being undertaken in developing the Nursing, Midwifery and AHP Strategy, noting the need to align with the Trust's other strategies.

045 **Serious Incidents and Learning from Events Report**

The Director of Nursing and Midwifery presented the Serious Incidents and Learning from Events Report which provides an update with regard to the number of serious incidents reported through STeiss to the commissioners last financial year. She advised that there were sixteen SIs reported in 2018/19 compared to twenty-four in 2016/17 and twenty-five in 2017/18; of the sixteen reported, eight related to gynaecology, five to maternity, two to neonates and one in genetics.

The Director of Nursing and Midwifery reminded the Board of the process a SI goes through advising that the Trust had sixty working days to undertake a root cause analysis (RCA) investigation and action plan. The commissioner then undertakes a review of the SI report and feedback comments to the Trust. The Director of Nursing and Midwifery advised that she had received positive feedback from the commissioners regarding presentation of the report, noting the involvement of clinicians in the feedback. The Board noted that all Sis were reported through the Safety Senate for monitoring and scrutiny and also to the Quality Committee for assurance.

Referring to Never Events, the Director of Nursing and Midwifery advised that two had been declared in the year, one related to a retained swab and the other related to the wrong coil being fitted; both of these had previously been reported to the Quality Committee and escalated to the Board. The Chair asked whether lessons had been learned with regards to the never events. In response the Director of Nursing and Midwifery reported that changes had been made to the processes and procedures that should address the never events in particular the learnings were assisting the publication of the Local safety standards for invasive procedures (LocSSIPs).

The Chief Executive advised that she had asked that the Fair and just Culture be applied past Never Events and that the findings would be reported into the Quality Committee.

Action 2019/045: The Director of Nursing and Midwifery to follow up the Fair and just Culture reviews of past Never Events and report the findings to the Quality Committee for assurance.

The Board noted the content of the SI Report.

046 **Safer Nurse/Midwife Staffing Monthly Report Period 11 2018/19**

The Director of Nursing and Midwifery presented the safer staffing report for month 11 which was taken as read. 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.

047 **Performance Report Period 11 2018/19**

The interim Director of Operations presented the Performance Report for period 11 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 interim Director of Operations advised on the significant challenges the Trust was facing to meet the 62 day Cancer targets which included having appropriate access and availability to

theatres at both the Trust and the Royal Liverpool. She explained that demand and capacity modelling had evidenced that admitted oncology demand required an additional three Gynae-Oncology theatre lists weekly and staff to support this; to support the demand one Advanced Training Skills Modules (ATSM) Oncologist commenced employment at the Trust in March 2019 and a business case was being developed the additional two posts.

Referring to RTT incomplete 18 week pathways; the interim Director of Operations reported that performance remained constant at 85% in December/January with focus continuing on managing long waiting patients and ASI lists. She advised that, although capacity issues persist in Uro-Gynaecology, two Consultants were successfully recruited in March 2019 to address the shortfall. With regards to the 52 week wait patients, the interim Director of Operations reported that these continued to reduce in number and explained that she had commissioned clinical harm reviews to be carried out on all patients to identify any harm on patients resulting from the delays. The interim Director of Operations reported that one patient required Percutaneous tibial nerve stimulation (PTNS) Physio awaits outsource as treatment no longer offered at the Trust and the Trust was exploring an alternative solution for the patient. The interim Director of Operation's advised that there continued to be operational focus on data validation ascertaining next steps in patients' pathways, reporting that this was completed for all 40 plus week patients and that focus moving forward would be in validating the 30-39 week patients to reduce likelihood of future breaches.

Referring to diagnostics, the interim Director of Operations reported that the Trust had failed its target by 1.7% in February 2019. She explained that the two most challenged areas were cystometry and uro-dynamics capacity due to consultant vacancies within uro-gynaecology. To improve capacity and capability two new uro-gynaecology Consultants had been recruited, to start in May 2019, with diagnostic sessions scheduled into their job plans.

Referring to the support the Trust had received from the NHSI Intensive Support Team (NHSI IST), the interim Director of Operations advised that the assurance work that they had provided so far was now producing dividends. She explained that IST had made three visits to the Trust, most recently on 27th March where it was recognised that the Trust had made significant progress, aided by a full operational team being in place; and was in the process of producing an overarching action plan which allows for continuous robust assessment of progress and supports managers in holding individuals to account through the governance structure. The interim Director of Operations advised that the Trust's Access Policy had been reviewed and amended, with IST providing some very positive feedback. She advised that IST recognised there was still a gap within the training programmes for RTT and Cancer which would require administrative, operational and clinical involvement. The interim Director of Operations explained that this would help to support the management and rules of engagements of RTT and would be facilitated from an external provider.

The Chief Executive thanked the interim Director of Operations and felt that she was bringing a different perspective and more robust processes on RTT and Cancer that would show dividends as the month's progress. The Chief Executive expected that the Quality Committee would be sighted on the improvements. Phil Huggon recognised and supported the need for training of all staff and asked how far off the Trust was in getting fully on track. The interim Director of Operations reported that she hoped that both RTT and Cancer would be on the right track by August 2019.

Susan Milner referring to the suite of KPIs felt that it was important the Board had sight of the full suite of KPIs that were reported in the Trust. This was discussed and it was agreed that the process of identification of indicators should be referred to the Board, with agreed Board and Board Committee indicators being reported into the Board Committees on 23 April 2019 and Board on 2 May 2019.

Action 2019/047: The interim Director of Operations to present the process for the

identification of indicators used by the Trust at, divisional, senate Board Committee and Board and to provide the requisite indicators for each Board Committee to review at their meeting on 23 April 2019 and the Board indicators at the Board on 2 May 2019.

The Board noted the Performance Report for period 11, 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 her report.

048 Financial Report & Dashboard Period 11 2018/19

The Director of Finance presented the Finance Report and financial dashboard for month 11, 2018/19 and reported that at month 11 the Trust was reporting a deficit of £0.3m against a deficit budget of £2.1m, giving a year to date favourable variance of £1.8m. She advised that the forecast for the year end, as reported at the February 2019 Board, had not changed was the delivery of £0.6m deficit for the full year, £1m ahead of the agreed full year control total. This included £0.5m of additional Provider Sustainability Funding.

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", as reported under the Chairs report for FPBD, continued to be due to sustained over-performance against plan over a number of months, and the crystallisation and management of a number of key risks.

The Chair thanked the Director of Finance for presenting the Financial Report & Dashboard Period 11, 2018/19 which was noted.

049 Future Generations

The Chief Executive reported on the arrangements being put in place for the clinical summit due to be held on 11 June 2019. She advised that clinicians were very concerned following the application for capital funding being refused by the Department of Health and Social Care and were undertaking pieces of work, looking at the future provision of women and neonatal services in the City and its impacts on other providers in the City. The Chief Executive explained that one of the pieces of work was to review the current age profile of clinicians, given a number were approaching retirement and what impact this would have on the services. She advised that the findings could articulate what services would remain in the City and what services would have to be provided elsewhere.

The Chief Executive advised that the Board would be looking to make some significant decisions on the future service provision of the Trust by August/September 2019. She felt that this was going to be very challenging in the delivery of services going forward with some services being at risk of being delivered in the City. The Chief Executive advised that above all Trust had to provide safe services and if it could not then these services would be at risk.

050 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 the amendments identified in the paper and approved the reduction of the risk score relating to the corporate risk "delivery of the annual plan 2018/19" to 10 by reducing the likelihood of the risk from 3 to 2.

The Chief Executive reported that she had discussed with the Director of Nursing and Midwifery and Head of Governance and Quality, how the BAF could be reported in the future, utilising the Ulysses data system that the Corporate Risks currently reside. She advised that this would be concurrent

with the current process and reported that the new system would need to be fit for purpose.

The Board received assurance from the Board Assurance committees that the risks were being appropriately managed.

051 Review of risk impacts of items discussed

The Board noted the following additional risks identified during the meeting:

- Staff Survey – provision of high quality care as business as usual.
- Staff Survey isolated site – creating a negative impact on staff morale given no movement in the preferred option
- Delays in diagnostics continued to be an issue for the Trust
- Financial Position for 2019/20 and the risks of delivery of a break even control total.
- Future Generations – strategic and clinical impact on the Trust which would crystallise on the provision of services in the future.

052 Any other business & Review of meeting

There was no other business.

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 2 May 2019.

Agenda Item 2019/067

TRUST BOARD
2 May 2019
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	
4 April 2019	2019/045	The Director of Nursing and Midwifery to follow up the Fair and just Culture reviews of past Never Events and report the findings to the Quality Committee for assurance.	Director of Nursing and Midwifery		*Proposed amendment to the action: Following a recent serious incident event, the executive considered that it would be more appropriate for the fair and just criteria be considered against the serious incident in parallel with the investigation.*
4 April 2019	2019/047	The interim Director of Operations to present the process for the identification of indicators used by the Trust at, divisional, senate Board Committee and Board and to provide the requisite indicators for each Board Committee to review at their meeting on 23 April 2019 and the Board indicators at the Board on 2 May 2019.	Interim Director of Operations	2 May 2019	To be discussed in a separate session of the Board on 2 May 2019. Completed

	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	2019/069

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Chief Executive Report**
DATE OF MEETING:	Thursday, 02 May 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.

Report

SECTION A - Internal

Dedicated to Excellence Awards 2019 - More than 250 people from Liverpool Women's NHS Foundation Trust including staff, volunteers, governors and key stakeholders came together to celebrate the hospital's glittering annual Dedicated to Excellence Awards ceremony on the evening of Thursday 18th April at The Crowne Plaza Hotel, Liverpool City Centre. Thank you to all staff attended the event and to the external sponsors. The list below details the winners:

Dedicated to Non-Clinical Innovation and Improvement
- 100,000 Genomes Project - This Gene-ie ain't going back in the bottle – Genetics

Dedicated to Clinical Innovation and Improvement
- Delivery Room CPAP quality Improvement Project (DR CPAP QIP) - NICU

Dedicated to Working Together (Team working and Partnerships)
- Reducing term admissions to minimise separation of mothers and babies – Maternity/NICU

Dedicated to Research
- ANODE: prophylactic Antibiotics for the prevention of infection – Research Midwives

Dedicated to Patients and their Families

- What's behind the door? - MLU

Dedicated to Patient Safety

- Right Care, Right Treatment - Communications

Dedicated to Clinical Audit

- On Our Breast Behaviour - Genetics

Staff Fundraiser of the Year

- Choir Raises Funds for NICU

Mentor of the Year

- Barbara Freeman – PALS

Learner of the Year

- Chris McGhee - Fair and Just Culture

Employee of the Year

- Sarah Orok - Gynaecology Outpatients

Team of the Year

- NICU Infant Feeding Team

Volunteer of the Year

- Mary Garner – Matbase

Patient Choice Award

- Richard Russell – The Hewitt Fertility Centre

Foundation Award

- ANODE: Prophylactic ANtibiotics for the Prevention of Infection Following Operative DElivery (Research)

Chief Executive Outstanding Contribution Award

- Sharon Owens - Gynaecology Emergency Department and Early Pregnancy Unit Manager
- Linda Martin - Patient Facilities Manager
- Congratulations to all involved with…BBC Hospital

Experience of care week 22nd – 26th April 2019: Experience of care week is an international campaign supported by both NHS England and NHS Improvement and offers organisations the chance to celebrate the work that that's happening to improve experiences of care. Some of the activities that took place in the Trust are:

- There was a Patient Experience Stall in main reception all week staffed by clinical staff, volunteers, patient experience team and the Governors
- There was a 'Ask the Matron' social media question and answers sessions this was also on Facebook
- Cupcakes and fruit were distributed to patients and their families with their morning drink donated by the League of Friends and given out by Deputy Director of Nursing, Matrons and League of Friends
- Patient Experience Stall on Digital Day on the 25th April launching Electronic Patient Information Leaflets
- Governor Walkabout recruiting new membership

#Generation IT comes to Liverpool Women's: Thursday 25th April 2019 saw its very 1st Digital Day, with digital suppliers demonstrating to the staff and patients the transformation that's underway at the trust. With 20 suppliers joining us to show how our Lexmark Managed Print Service has delivered on its promise of 30% cost reduction to productivity improvements through to B.Braun demonstrating the ground breaking Theatre Stackers which have been implemented in Gynae Theatres. In addition our very own Virtual Reality for the 1st Trimester of pregnancy received a crowd and a queue waiting to see the works we have done and are continuing to undertake, with positive messages from L&D wanting to develop with us a way of VR working for them* which would again be a first of its kind. We also have new innovative works planed such as digitising the Milk Bank through to Sensor technology keeping our patients safe. A special thanks to Paula Brennan (Programme Manager) and the PMO team for all their efforts in delivering the day, they not only created the event which was cost neutral but also raised approx. £1000 towards Big Tiny Steps. Margi Dalton – Genetics Admin also won the donated Fit bit from Lexmark for the word search, which many members of the staff took part in so Well Done.

Expressions of interest to host The Innovation Agency (Academic Health Science Network for the North West Coast): The Trust has put forward an expression of interest to host The Innovation Agency to provide the following support services: Finance; Procurement and Contract Management; Telephony, post, delivery and supplies; Human Resources, including Payroll; IM&T support; and Corporate services, including Governance and other administrative support. This is the very first step in a process that would include: the process and timeline for submitting a tender; service specifications for the core services required; and Tender response templates.

Making Every Contact Count (MECC): Making every contact count (MECC) is an initiative being implemented within the Trust that enables staff to be proactive in facilitating greater awareness to patients and service users of health and wellbeing initiatives. The Trust is already undertaking some great work in giving advice on smoking, alcohol and weight and there are a number of CQUINS to support this. Liverpool CCG have requested that the Trust build on the great work that is already being undertaken both for patients and staff to include other healthy initiatives to prevent ill health, improve health and wellbeing and to reduce health inequalities.

- MECC will be part of normal pathways
- The implementation and action plan will be reviewed by the CCG
- The action plan will be monitored quarterly at patient experience senate
- Staff will need to be trained and champions identified
- This is a long term programme to reduce health inequalities

Operational Plan 2019/20: On 4 April 2019 the Trust submitted its Board approved financial and operational plan 2019/20. The Trust has been able to develop a financial plan for 2019/20 which delivers the breakeven control total set by NHS Improvement (NHSI). This is a challenging plan to achieve and contains a number of risks to delivery however a solid and robust process of challenge and prioritisation has been undertaken across the organisation to achieve this position. The plan reflects ongoing investment in the clinical case for change and keeping services safe on site whilst the Trust continues to push forward in enacting the preferred option of co-location with the local adult acute provider.

SECTION B – Local

North West Ambulance Service: Board Changes- Chief Executive/Chairman/Medical Director/Director of Finance :
Chief Executive: Daren Mochrie joined the trust as chief executive on 1 April 2019 following an intensive recruitment process involving commissioners, non-executive directors and external representatives. Daren has worked in the NHS since the age of 17. He has extensive experience of managing ambulance services in both rural and urban settings. Prior to this role he held positions as chief executive at South East Coast Ambulance Service and director of operations at Scottish Ambulance Service.

Chairman: Peter White took up the role of Chairman of North West Ambulance Service on 1 February 2019 following the departure of Wyn Dignan. From the Ribble Valley in Lancashire, Peter has enjoyed a varied career policing all areas of Lancashire before being promoted to senior positions including head of uniform operations, commander of Preston division, head of the force's corporate change programme and finally assistant chief constable responsible for the people portfolio. Peter, who was previously Vice Chairman at NWAS, had been a Non-Executive Director at the trust since 2014, with specific responsibility for performance and quality as well as leading on behalf of the board on emergency preparedness, resilience and response.

Medical Director: Chris Grant joined the board of directors on 1 April 2019 in the role of medical director following the departure of David Ratcliffe. Chris has undertaken numerous senior roles in both the acute and NHS commissioning sectors. Latterly he has led system changes in Liverpool that redesigned the way services are shaped to match the population needs. He joined NWAS six months prior to taking up the medical director post, to help

drive improvements to both the medical and quality directorates. Chris will continue to work at the major trauma centre in Liverpool as a consultant in critical care medicine.

Finance director: Also joining the board on 1 April 2019 was Carolyn Wood, Director of Finance. Carolyn has a broad range of financial services experience and knowledge from working within a range of organisations in the North West, including acute providers, commissioners, NHS England and the Strategic Health Authority. Carolyn was previously the Director of Finance for Oldham Care Organisation, part of the Northern Care Alliance NHS Group, comprising Pennine Acute Hospitals and Salford Royal Hospitals.

Chairs Reports to be added

Agenda Item	2019/074

MEETING	**Board Meeting**
PAPER/REPORT TITLE:	**Guardian of Safe working Hours Annual Report 2018/19**
DATE OF MEETING:	Thursday, 02 May 2019
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Devender Roberts, Acting Medical Director
AUTHOR(S):	Rochelle Collins, Medical Staffing Manager
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** **1.** To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☐ **2.** To be ambitious and ***efficient*** and make the best use of available resource ☒ **3.** To deliver ***safe*** services ☒ **4.** To participate in high quality research and to deliver the most ***effective*** Outcomes ☐ **5.** To deliver the best possible ***experience*** for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *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 receive the*** **Guardian of Safe working Hours Annual Report 2018/19**			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Putting People First Committee Or type here if not on list: ***Click here to enter text.***	
	Date of meeting		PPF receives a quarterly report with a consolidated annual report presented to the Board.	

Executive Summary

Under the 2016 terms and conditions for doctors and dentists in training introduced by the Department of Health nationally on 5th October 2016, there is a requirement for the guardian of safe working hours (GSWH) to submit a quarterly report to a sub board committee and an annual report to the Trust Board. The Putting People First Committee has received these reports quarterly.

The new contract highlights three functions, which oversee the safety of doctors in the training and service delivery domains of their working experience:

a. The employer or host organisation designs schedules of work that are safe for patients and safe for doctors, and ensures that work schedules are adhered to in the delivery of services.

b. The Director of Medical Education (DME) oversees the quality of the educational experience.

c. The Guardian of Safe Working Hours provides assurances to the employer, and host organisation if appropriate on the compliance with safe working hours by the employer and the doctor.

The GWSH supports safe care for patients and the health and wellbeing of doctors in training through the management of exception reporting. The role ensures any issues of compliance with safe working are addressed as appropriate by the Trust. The guardian has the authority to impose sanctions such as a doctor taking time back in lieu of working additional hours or levy financial penalties against the departments where safe working hours are breached.

The Guardian is confident that doctors in training receive appropriate work schedules and compliant rotas. This is evident in the number of exception reports received by the Guardian in the reporting year, a total of 8 exception reports were lodged by O&G trainees only. There were no work schedules review requests.

The national shortage of junior doctors is proving to be a significant challenge to the Trust. The most affected specialty is O&G who host a number of female trainees who work less than full time, this is a national trend and not unique to Liverpool Women's.

During this reporting period, the services ran with a number of rota gaps resulting in the following shifts requiring locum cover. Obstetrics and gynaecology 398, Neonates 105 and Anaesthetics 123 shifts requiring cover by either a doctor in training, an agency doctor or a consultant. Of the 398 shifts requiring cover in O&G 8 shifts were unfilled. However, it should be noted, that at no point did the Trust consider the staff levels to be in adequate as the unfilled shifts were during the hours on 17:00 – 21:00 when there was senior medical representatives on site.

Report

Introduction

The Guardian of Safe Working Hours is a requirement of the 2016 contract and is currently filled by Mr Geoff Shaw (Consultant Obstetrician). The Guardian is responsible to the Medical Director and should not be involved in management roles within the Trust, but have a fully independent role with access to the Board as required.

The role of the Guardian is to;

- Act as a champion of safe working hours
- Record and monitor compliance of exception report management and review cases escalated by a doctor in training
- Escalate issues for action where not addressed locally
- Will request work schedule reviews to be undertaken where necessary
- Oversea safety-related exception reports and monitor compliance with the system
- Intervenes as required to mitigate safety risks
- Intervenes where issues are not being resolved satisfactory
- Provide assurances on safe working and compliance with TCS
- Submits a quarterly report to the Trust Board on the functioning of the contract and exception reporting

Work Schedules

NHS Employers recommend that doctors in training should be made aware of their next placement 12 weeks before commencement. They should receive work schedules 8 weeks prior to commencement and a finalised rota 6 weeks before. This is to ensure work life balance it also enables doctors to request annual leave 6 weeks in advance.

Although the majority of work schedules have been completed within the 8-week timeline, this has not always been possible due to conflicting information from Health Education inaccurate or missing information from the college tutors and / or changes in the rota due to unexpected gaps. This information is currently reported quarterly to NHSI data collection.

Rota compliance

All rotas are complainant with both 2002 and 2016 terms and conditions. This is relevant as doctors training at the trust are on different terms and conditions yet work on the same rota. Therefore, it is paramount that all rotas remain compliant with both sets of terms and conditions.

Staffing Levels

Due to the national shortage of junior doctors, and as detailed on the trusts Risk Register, the Trust usually runs with a number of gaps on the rotas across all services. The majority of these gaps are in the main covered as locum shifts by the current cohort of doctors in training. However, there is a reliance on agency locums covering shifts in O&G, managed within the current framework agreement.

As referenced in the Guardians quarterly reports, the number of gaps fluctuate throughout the 12 months due the number of times each specialty rotates, maternity leave, long-term absence and the completion of training (CCT). Therefore as the year progresses the services expect to work with increasing gaps. For context, the table below highlights the rotation months for each service.

Rotations by month, specialty and grade.

Month	Specialty	Grade
August	O&G	F1 – ST7
	Anaesthetics*	CT2 – ST7
	Genetics	ST3 – ST7
September	Neonates	ST1 – ST7
November	Anaesthetics*	CT2 – ST7
December	O&G	F1 – F2
	Anaesthetics*	CT2 – ST7
February	O&G	GPST
	Anaesthetics*	CT2 – ST7
March	Neonates	ST1 – ST7
April	O&G	F1 – F2
May	Anaesthetics*	CT2 – ST7

*The Anaesthetic department trains doctors in higher obstetrics and these doctors rotate monthly. This is usually 1 -2 doctors at a time.

Obstetrics and Gynaecology

This workforce is predominately female; therefore as expected, there are a high number of gaps in this service due to maternity leave and less than full time working. Throughout the reporting period, the service has ran with an average of 6 gaps across the 3 rotas. The service runs with a 3 tier rota as described below. Historically, the service has not covered daytime gaps with locum doctors, however, the service has on occasion employed a long term agency locum to cover daytime and out of hours activity.

- Tier one - doctors within the first 4 years of training most of which will have no experience in obstetrics and gynaecology. Usually GP, Foundation and ST1&2 O&G doctors. These doctors are on the 2016 contract.
- Tier two – Doctors who have a minimum of 2 years of experience working in Obstetrics and gynaecology working at an ST3 – ST5 who have a career plan to progress within O&G. There is a combination of 2002 and 2016 contracted doctors on this rota.
- Tier three – Experienced obstetricians and gynaecologists who have part 3 MRCOG and more than 6 years O&G experience working at an ST6 – ST7. The majority of these trainees are on 2002 contract.

Trainees are given protected time to attend in house teaching organised by the college tutors for the first week of every month. The teaching is for ST1 to ST7 training grades. The teaching is facilitated by external and internal speakers. However, during quarter 3 and quarter 4 of this reporting period the service has found it increasingly difficult to release trainees for teaching. This has been raised at the previous two junior doctor forums. The DME has agreed to work with the college tutors to identify time when the teaching may be 'paid back' to the trainees. Trainees are also invited to attend quarterly meeting with the college tutors and HR on a Friday morning 'early bird' session to discuss issues and concerns as well as updates about their rota and training needs.

The service continues to experience increasing problems with maintaining adequate staffing levels throughout the year in particular, experienced staff on tiers 2 and 3 of the rota. This can potentially lead to patient safety issues. Throughout the year, the service attempts to mitigate this by employing a combination of Clinical Fellows and Research Fellows and more recently, International Training Fellows and Academic Clinical Fellows/Lecturers. Currently the Trust employs 7.8 'Trust Grade' non-training doctors in addition to the doctors in training. The service also uses bank and doctors in training to cover out of hour rota gaps with agency doctors being sourced as a last resort.

To mitigate the gaps further, in quarter 4, the service 'acted up' three ST2 trainees who are now competent to work at a registrar level. The doctors are also aware of their limitations and aware of how to escalate if necessary. The college tutors continue to support the ST2 doctor's acting up until August 2019 and if there is any concern, this will be addressed. However, this has impacted on the Tier one rota. To mitigate these gaps the Trust employed a Foundation Year 3 doctor in quarter 4 on a fixed term contract.

The Trust works in partnership with Edge Hill University in recruiting International Training Fellows who work clinically at the Trust whilst completing a Masters. In quarter 3 the Trust recruited 2 International Training Fellows from India. The doctors started on the Tier 1 rota and by quarter 4 progressed to the Tier 2 rota as they are now competent to work at a registrar level. The Trust has committed to employ two doctors per year for 3 years whilst the doctors undertake a Master's programme.

The Trust continues to work in partnership with the University of Liverpool and the Tropical School of Medicine, jointly employing a clinical academic who will work 2.5 days clinical and 2.5 days academic.

In addition to the already mentioned Trust posts, in quarter 4, the service submitted a business case for funding for a further 4 posts. The funding has been approved and HR continue to work with the Director of Medical Education and the Clinical Directors to ensure posts are advertised in good time so that the successful candidates are appointed in time for the next rotation (August 2019).

For context, during this reporting period the service required locum cover for 398 out of hour shifts to be covered by the following staff members, Junior Doctors, bank doctors, agency doctors and consultants acting down. This, compared to last year 285 is a 40% increase in shifts requiring locum cover. During this reporting period 8 shifts were unfilled. However, it should be noted, that at no point did the Trust consider the staff levels to be in adequate as the unfilled shifts were during the hours on 17:00 – 21:00 when there was senior medical representatives on site.

Anaesthetics

The Anaesthetic service runs with an average of 4 – 5 gaps per year. To mitigate the known gaps in the service, the service employs Trust Grade doctors, who are commonly referred to as Clinical Fellows. Also, the service at times, receives a trainee from Wales, the Welsh doctor has a Welsh training number and is therefore not included in

Health Education England numbers. The Clinical Fellows are usually employed for a fixed term period of 3 to 6 months whilst they are preparing for exams and / or applying for ST3 rotation. This works extremely well as the majority of these doctors have previously worked at LWH as Core Trainees and therefore are well trained and familiar with the Trust and its complexities.

The service runs a 2 tier rota for on call work which equates to 4 x 12.5 hour shifts, 2 daytime and 2 at night. Therefore the service needs to cover both daytime and night time gaps with bank / lead employer doctors working locums. For reference, due to the training and specialist nature of the Trust, the service does not use agency doctors. The service has not reported any concerns with trainees being released for teaching. The main issue is the fact at times, the core trainee exam is scheduled on the same day as regional teaching for ST3 upwards. This can prove a difficult when trying to staff rotas. Occasionally, doctors may have their annual leave and or study leave refused. However, the service makes every effort to ensure this only happens in exceptional circumstances.

For context, during this reporting period the service required locum cover for 123 shifts to be covered by the following staff members, Junior Doctors and bank doctors. This, compared to 86 last year, this is a 43% increase in shifts requiring locum cover.

Neonates

The Neonatal service runs with an average of 2 gaps. During this reporting service, the service has not employed any Trust Grade Doctors as they are often reliant on Advanced Neonatal Nurse Practitioners (ANNP). Also due to the specialist nature of the service the service does not use agency staff. To mitigate gaps in the rotation, the junior doctor workforce works alongside the ANNP's (who are well established at LWH and are trained to work at registrar level.

The service has not reported any concerns with junior doctors and has highlighted GMC survey results for paediatric doctors (national survey) highlighted Liverpool Women's NHS Foundation Trust Neonatal unit as one of the best training sites within the country. The service has no issues with training or opportunities for teaching. The teaching takes place 5 mornings a week for 30 minutes and includes but not limited to, radiology, journal club, case presentations and consultants lead teaching. The Registrars (ST4 +) complete 1 week of teaching every 6 month in partnership with Arrowe Park. In the survey local teaching and curriculum coverage was highlighted as excellent.

For context, during this reporting period the service required locum cover for 105 out of hour shifts to be covered by the following staff members, Junior Doctors and ANNP's. This, compared to 49 last year, this is a 114% increase in shifts requiring locum cover.

Exception Reporting

Doctors in training are expected to electronically submit exception reports via the doctors rostering system (DRS) detailing if they have worked over their scheduled hours, missed breaks or educational opportunities. These exceptions are managed by the doctor's educational supervisors, and where appropriate the GSWH and or the Director of Medical Education (DME).

As detailed in the table below, the number of exception reports has been minimal with the majority of them being reported in quarter 3 and quarter 4. This trend fits in with the fluctuating staffing levels in each specialty.

Numbers of exception reports recoded on the electronic reporting system are listed below; between April – November 18 no exception reports recorded.

Month	Specialty	Grade	Reason	No: hours	Out come
Dec	O&G	ST1	Hours	3.5	Time back in lieu
Feb	O&G	GPST2	Hours	1	Time back in lieu
Feb	O&G	ST1	Rest/Education	n/a	Not answered
Mar	O&G	ST1	Hours	n/a	Not answered (however this will not be agreed as within rota template)
Mar	O&G	ST1	Hours	0.45	Not answered
Mar	O&G	ST1	Hours	1	Not answered
Mar	O&G	GPST	Education	n/a	Not answered
Mar	O&G	ST1	Hours	1	

The majority of the recoded exception reports relate to hours due to lack of staffing. Due to the increasing complexity of patients being cared for at the Trust, this is often the case and as described in the exception report, doctors in training have noted that the overrun was due to a complicated case / patient. However, during the last quarter the O&G service has seen an increase in the number of exceptions due to poor staffing and missed education opportunities. There is a number of outstanding exceptions on the system which is due to annual leave. The GSWH is addressing this as a priority with the education supervisors.

Engagement of junior Doctors

The GSWH continues to attend doctor in training inductions and offers support to all doctors. The doctors are aware of the GSWH and the role. There is also an encouragement for doctors to complete exception reports as it is a useful tool when looking at workforce planning. Doctors are offered exception reporting training as and when they need it, however to date no one has taken up this offer nor advised the GSWH or HR of any issues when using the system.

All services continue to engage with junior doctors and offer supportive and safe environments for doctors to work. The doctors have access to the Guardian of Safe Working Hours and the Freedom to Speak up Guardian.
The doctors are also encouraged to discuss any issues relating to safe working, practices or behaviours with their educational supervisors.

During the first 2 quarters of this reporting period the junior doctor forum were poorly attended, this is a trend across the region. However, as recognised in the previous report as the number of doctors employed on the 2016 contract increased the attendance would also increase. This has been the case and in the last 2 quarters the number of attendees has increased and become a useful platform for the doctors to raise any concerns. The forum also gives the Trust the opportunity to address and issues.

Fines

There are no fines to report.

Issues for Consideration

The GSWH continues to be concerned about the number of rota gaps particularly at the ST5 plus grade and the trend for doctors to apply for an out of programme period to complete research in neighbouring Trusts such as Manchester.

Although there are not many exception reports lodged the GSWH believes that there is a trend for doctors not to report exceptions as they have advised in forums and outside of forums that they value the exposure and experience they gain from complex cases / patients. The Trust will continue to encourage doctors to submit exception reports.

The committee should be aware that given the number of additional shifts the current doctors are working in addition to their normal timetable there is a risk of 'burnout' amongst the trainees. HR is working with the rota coordinator and the college tutors to review recent sickness amongst this workforce and compare the data with the locum (gaps) usage data to address any concerns about health and wellbeing.

Actions Taken

The Trust's Strategic Workforce Group continues to work together to help to mitigate the junior doctor shortages and develop medium and long term plans for alternative posts. In particular the Chair and Director of Medical Education continue to work closely with HR addressing workforce issues within the Trust.

The Guardian of Safe Working Hours is currently working on an Educational Supervisors SOP for how to address exception reports including specific timescales in line with the junior doctor Terms and Conditions of Service 2016. This will ensure all exceptions are responded to and resolved in good time and escalated where necessary.
The Guardian is continuing to engage with junior doctors at their scheduled forums and continues to promote the use of the exception reporting system.

The O&G and Anaesthetic service will continue to recruit to 'Clinical Fellow' (Trust grade doctor) roles throughout the year.

The Trust is also engaged with the BMA looking at the 'fatigue and facilities charter'. The Trust will use the guide to make improvements where it can and therefore agree to the charter in principle.

Recommendation

The Board is asked to receive the **Guardian of Safe working Hours Annual Report 2018/19**

Agenda Item	2019/075(i)

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**
DATE OF MEETING:	2nd May 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.*** *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……* ☒ *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: **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 organisation 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: Trust Board		
	Date of meeting	Thursday, 02 May 2019		

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 March 2019 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 currently 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 of **March 2019.**

- Gynaecology has seen an increase in fill rate from January and February
- Delivery suite has seen an overall increase in fill rates from January and February
- Maternity Base has seen a decrease in RM fill rate but an overall increase in support worker fill rate
- MLU has seen an increase in overall fill rate
- Jeffcoate has seen a decrease in support worker fill rate
- Neo- natal has seen an increase overall

Staffing is monitored across maternity every 4 hours by the 104 bleep holder who has an over view of the whole of maternity service. Staff are moved between areas depending on activity.

2.2 Red Flags

March 19 – Red Flags : There were a total of 18 incidents reported under the Nursing / Midwifery red flag criteria. 4 were relating to staffing shortfalls.

Investigations into these concluded that staffing levels and skill mix were safe at the time and did

not contribute directly to any incidents.

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 0 vacancies across Maternity however, there are 10.69 WTE on Maternity leave. 1.0 WTE registered nurse vacancies on the Gynaecology Ward however, 4.0 WTE on maternity leave. 1.0 WTE band 5 vacancies in Neonates with 5 WTE on maternity leave. 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. The action plan has been submitted and is being monitored through NPF and PPF.

Further work is currently being undertaken 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 month of March 2019 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 within all divisions.

6.0 Recommendations

The Board is asked to note:

- The content of the report and be assured appropriate information is being provided to meet the national and local requirements.
- The organisation has the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Director of Nursing & Midwifery

Appendix 1

March 2019

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	100%	98.4%	100%	100%
Delivery Suite	86.4%	72%	93.8%	72%
Mat Base	86.3%	64.5%	88%	83.9%
MLU	94.4%	54.8%	96.8%	67.7%
Jeffcoate	96.8%	67.7%	93.5%	48.4%
NICU	107.3%	109.7%	102.8%	103.2%

Agenda Item	2019/075(ii)

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	Review of Headroom Percentage and Birth Rate Plus
DATE OF MEETING:	Thursday, 02 May 2019
ACTION REQUIRED	**For Approval**
EXECUTIVE DIRECTOR:	Caron Lappin, Director of Nursing
AUTHOR(S):	Janet Brennan, Deputy Director of Nursing 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):	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 revised Headroom percentages for use in budgets, business cases and other calculations of required staff numbers.*** ***The Board is asked to approve the application of Birth Rate Plus as outlined in the paper.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Putting People First Committee (Considered a detailed paper on Birth Rate Plus)
	Date of meeting	23/04/2019

Executive Summary

1. Headroom

Headroom is the term used to calculate the number of whole time equivalent staff required to provide cover against a rota, to take account of sickness, annual leave, training and other time away from work. Typically it does not cover maternity leave.

At LWH in 2018/19, a figure of 18.9% was used throughout the Trust in all specialities. This benchmarks as low against other trusts, and managers identified that it did not allow sufficient time for clinical staff to complete all required training.

As part of the 2019/20 budget setting and operational planning process, the value was re-assessed by looking at up to date data across all areas. It has been re-calculated and the revised percentages used in setting budgets.

The Board is asked to approve the revised percentages for ongoing use. These will be reviewed annually during budget setting.

2. Birth Rate Plus

Up to 2018/19, a ratio of midwives to births was used to ensure there were a safe number of midwives budgeted for. This was approved by the LWH Board as 1 midwife to every 29.5 births.

However more recently, the "Birth Rate Plus" acuity modal ratio has been developed, giving a more detailed assessment of required staff based on the volume and type of activity undertaken.

This was considered in detail and agreed at the Putting People First committee and is agreed by the Head of Midwifery as providing a safe number of staff, based on an assumption of 8,200 births. It is reflected in agreed budgets, which represents an investment in midwifery staffing, subject to final Board approval.

The Board is asked to approve the application of Birth Rate Plus as outlined below.

Report

1. Headroom

Data has been gathered as to the levels of sickness, annual leave and training in each area. These have been validated by management and clinical leadership.

The calculation supporting the 2018/19 and proposed 2019/20 headroom values are given in the table below.

	CURRENT			PROPOSAL - MATERNITY			PROPOSAL - OTHER SPECIALTIES		
	INPUT	HOURS	%	INPUT	HOURS	%	INPUT	HOURS	%
Contract Hours per annum	37.5 x 52	1,950.00	**100%**	37.5 x 52	1,950.00	**100%**	37.5 x 52	1,950.00	**100%**
HEADROOM									
Annual Leave	28.00 Days	210.00	**10.8%**	31.00 Days	232.50	**11.9%**	31.00 Days	232.50	**11.9%**
Bank holidays	8.00 Days	60.00	**3.1%**	8.00 Days	60.00	**3.1%**	8.00 Days	60.00	**3.1%**
Training	4.00 Days	30.00	**1.5%**	5.00 Days	37.50	**1.9%**	4.00 Days	30.00	**1.5%**
Maternity leave	0.00 %	0.00	**0.0%**	0.00 %	0.00	**0.0%**	0.00 %	0.00	**0.0%**
Sickness Absence	3.50 %	68.25	**3.5%**	4.50 %	87.75	**4.5%**	4.50 %	87.75	**4.5%**
TOTAL HEADROOM			**18.9%**			**21.4%**			**21.0%**

The revised calculation is based on an assessment of actual leave entitlement (which is 31 days on average for the clinical workforce at LWH) and rebased to match the Trust's sickness target of 4.5%.

Bank holidays clearly are unchanged.

Training was also re-assessed and reviewed in detail with managers and clinical leadership, with the relevant Head of Nursing/Midwifery agreeing the mandatory training requirement for each area. This averages at 5 days per year for Maternity and 4 days per year for all areas per the table above. This has also been discussed more widely in each division and in cross divisional planning meetings, and reviewed and agreed by the Deputy Director of Nursing and the Director of Nursing as appropriate.

The headroom as outlined above will allow appropriate cover to be maintained in clinical areas and training to be completed. It will also support the roster challenge meetings and process, as all budgets are built up from expected rotas with the headroom above applied.

Note that maternity leave will remain a pressure on budgets.

2. Birth Rate Plus

The Birth Rate Plus tool allows the calculation of the required number of midwives, support staff and non direct care giving staff (e.g. managers) based on the type of activity in each setting. A summary of the output of the tool is given below, with full detail in Appendix One.

	SPLIT			WTE			
	Clinical	*Support*	*Non Direct Care*	Clinical	Support	Non Direct Care	Total
Delivery Suite	***90.0%***	***10.0%***	***9.0%***	80.63	8.96	8.06	**97.65**
Midwifery Led Unit	***90.0%***	***10.0%***	***9.0%***	26.23	2.91	2.62	**31.77**
Maternity Base	***70.0%***	***30.0%***	***9.0%***	49.38	21.16	6.35	**76.89**
Community	***70.0%***	***30.0%***	***9.0%***	58.75	25.18	7.55	**91.48**
Other	***90.0%***	***10.0%***	***9.0%***	33.82	3.76	3.38	**40.95**
Total				**249**	**62**	**28**	**338.74**
CIP - Qualified/Unqualified				- 5	5		-
Total Budget				**244**	**67**	**28**	**338.74**

The whole time equivalent values above have been factored into 2019/20 budgets and funded, pending final Board approval. This staffing model is affordable and has been cross referenced to rotas. It factors in the revised headroom of 21.4% outlined above. The Birth Rate Plus tool gives a high level of assurance that there is a safe level of staffing for the expected number of births.

If the number of births or other activity were to increase, this would need to be re-assessed.

3. Recommendation

The Board is recommended to approve the revised headroom percentage and investment in Birth Rate Plus, as outlined above.

Appendix One- Full Birth Rate Plus Calculation

AREA	CATEGORY	Activity	Apportion Births	Apportion Activity	WTE
DEL SUITE	**Births**	**6,415**	**78.23%**	**78.23%**	78.03
DEL SUITE	Cat X	-		**0.00%**	
DEL SUITE	Cat A1	127		**1.54%**	0.46
DEL SUITE	Cat A2	175		**2.14%**	1.88
DEL SUITE	Inductions	3,290		**40.12%**	5.88
DEL SUITE	Cat R	102		**1.25%**	1.76
DEL SUITE	Escorted transfers out	16		**0.19%**	0.04
DEL SUITE	Non-viables	129		**1.57%**	1.54
MAU	Various	11,074		**135.05%**	18.53
MLU	**Births**	**1,704**	**20.78%**	**20.78%**	19.63
MLU	Unplanned Attenders	1,480		**18.05%**	1.00
MLU	Transfers to D/S	620		**7.56%**	5.05
MLU	P/N Care of births	1,338		**16.31%**	3.46
MATBASE ANTENATAL	Admissions	813		**9.91%**	4.37
MATBASE ANTENATAL	Ward attenders	-		**0.00%**	-
MATBASE ANTENATAL	Transfers for scans etc	-		**0.00%**	-
MATBASE POSTNATAL	Women	6,781		**82.69%**	58.48
MATBASE POSTNATAL	Ward Attenders	-		**0.00%**	-
MATBASE POSTNATAL	Re-Admissions	54		**0.65%**	0.28
MATBASE POSTNATAL	TC Babies	974		**11.87%**	5.03
MATBASE POSTNATAL	NIPE	-		**0.00%**	2.39
OUTPATIENT ANTENATAL	LWH Specialist	-		**0.00%**	1.94
OUTPATIENT ANTENATAL	LWH Consultant	-		**0.00%**	-
OUTPATIENT ANTENATAL	Fetal Maternal Medicine	-		**0.00%**	3.81
OUTPATIENT ANTENATAL	LWH M/W	-		**0.00%**	5.82
OUTPATIENT ANTENATAL	Aintree M/W	-		**0.00%**	1.61
OUTPATIENT ANTENATAL	Aintre Booking	-		**0.00%**	0.16
MAT DAY UNIT	LWH Day	4,870		**59.39%**	3.15
MAT DAY UNIT	Aintree Day	-		**0.00%**	2.55
COMMUNITY	**Home Births**	**82**	**1.00%**	**1.00%**	2.30
COMMUNITY	Cases (Full A/N & P/N)	5,218		**63.64%**	52.15
COMMUNITY	Cases (Reduced A/N)	2,198		**26.81%**	18.71
COMMUNITY	Cases (P/N Only)	1,682		**20.52%**	7.45
COMMUNITY	Bookings Only	1,505		**18.35%**	1.95
COMMUNITY	NIPE	-			1.37
					WTE
TOTAL	ALL CLINICAL				**310.77**
TOTAL	ALL NON CLINICAL				27.97
TOTAL	ALL				**338.74**

Agenda Item	2019/076

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Performance Report month 12**
DATE OF MEETING:	Thursday, 02 May 2019
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Loraine Turner, Director of Operations
AUTHOR(S):	Sarah Sherrington, Service Improvement & Business Manager
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *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	

1. Introduction

The full Trust performance dashboard is attached in **Appendix 1** below.

2. Performance

Indicator		Metric	Threshold		Actuals					Δ	Trend	Volume
					Oct-18	Nov-18	Dec-18	Jan-19	Feb-19			
Cancer	2WW for suspected cancer	%	≥93%	Higher values are better	96.8	95.3	95.2	97.1	99.0	▲		192
	31 Days from Diagnosis to 1st Definitive Treatment	%	≥96%	Higher values are better	60.0	91.3	95.0	93.3	90.3	▼		31
	62 Days for First Treatment from urgent GP Referral **(Before re-allocation)** Final Reported Position	%	≥85%	Higher values are better	44.4	54.5	77.8	66.7	50.0	▼		9
	62 Days for First Treatment from urgent GP Referral **(After re-allocation)** Final Reported Position	%	≥85%	Higher values are better	37.0	23.1	80.0	58.3	47.4	▼		9.5
	104d Referral to First Definitive Treatment	Count	0	Zero tolerance	2	5	0	3	4	▼		n/a
RTT	RTT Incomplete Pathways <18 weeks	%	≥92%	Higher values are better	87.1	87.2	85.9	85.5	84.9	▼		5452
	Incomplete Pathway > 52 Weeks	Count	0	Zero tolerance	14	14	11	5	3	▲		n/a

Cancer:

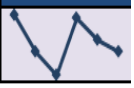
- February saw a decrease in performance due to uncharacteristically high levels of sickness amongst the small Consultant Oncologist workforce, with 50% off for a short period. All reasonable measures were taken to mitigate for this including pooling patients. The reduction in performance is anticipated to be short-term only as all Consultants have subsequently returned to work.
- The February re-allocation position was affected by one patient who was booked for surgery within the 62d target however did not attend an essential diagnostic at RLUH prior to surgery and subsequently could not be re-booked for this and re-dated for surgery within the timeframes.
- The 2WW target has improved again in February as renewed focus at PTL meetings, combined with appointing a dedicated Booking & Scheduling admin for this role, enables the matching of capacity to demand for Rapid Access Clinics. This forms part of the work which continues with NHSI IST and the Cancer Alliance to map timed clinical pathways and understand efficiencies which may be gained within the front end of pathways in order to realise subsequent positive gains within the 62d targets.
- Significant challenges to meet the 62d targets remain including appropriate access/availability to theatres at LWH and RLUH. Demand and capacity modelling has evidenced admitted oncology demand requires an additional 3 Gynae-Oncology theatre lists weekly at LWH, and staff to support this. There is a business case in development to support this going forward. One ATSM Oncologist (special interest Clinician) commenced in post March 2019 and business cases are being developed for additional posts.

RTT:

- February saw an increase of ~200 patients on the RTT pathway (Jan 5242 > Feb 5452) in part due to a surge of demand for Colposcopy services in response to the current national screening campaigns. Capacity across this service was reviewed and plans implemented to accommodate high grade patients and manage demand. Operational monitoring of the referral volumes continue to inform further planning of capacity.
- February also experienced significant challenges for gynaecology services due to high levels of Consultant sickness, with some long-term sickness thought to continue into March. Despite both these factors the RTT

incomplete 18 week pathway performance dipped by only 0.6% to 84.9% whilst also continuing to manage long waiting patients and reduce the 52week patients.

- Capacity issues persist in Uro-Gynaecology with 2 Consultants successfully recruited in March 2019 to address this shortfall. Consultants are due to start in post May 2019.
- Operations have continued to focus on managing long waiting patients and ASI lists. All 52 week patients have had clinical reviews with plans in place for next steps and appointments ghosted as required.
- 1 x patient requires PTNS Physio; a service no longer offered at LWH currently. Attempts to outsource the patient locally for treatment were unsuccessful due to PTNS capacity challenges regionally. The Trust has now placed an order to purchase the necessary equipment and training to re-establish this service.
- There is a continued operational focus on data validation ascertaining next steps in patients' pathways. This is complete for all 36+ week patients, with focus moving forward now on validating the 30-36week patients to reduce likelihood of future breaches.

Indicator		Metric	Threshold		Actuals						Δ	Trend
					Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19		
Diagnostics	Diagnostic Tests: 6 week wait	%	≥99%	Higher values are better	98.6	96.7	95.5	98.4	97.3	96.7	▼	

Diagnostics:

The Trust has failed this target by 2.3% in March. The two most challenged areas are cystometry and urodynamics capacity due to vacancy factor within the urogynaecology service, compounded by some staff sickness and leave also within in March. Two new urogyanecology Consultants have been recruited with diagnostic sessions scheduled into job plans. Consultants are due to start in post May 2019.

NHSI Intensive Support Team (NHSI IST):

From February 2019 NHSI IST has been providing additional expert support to the Trust following assessment against the Trust's recovery plan, in particular to focus on the following objectives:

1. **Pathway Design** – To review and revise pathways ensuring in line with best practice, include timescales for clinical events and administrative processes and equitable access across all sites. Gap analysis to be performed to be compliant with national standards and reduce waiting times.
2. **Access Policy** – To review the Trust Access Policy and the booking and admin processes for the cancer pathway to ensure they are consistent and streamlined.
3. **Cancer training strategy** - To undertake training needs analysis to include all staff who 'touch' the patient pathway, including clinicians
4. **Critical review of key Cancer Meetings** – To provide written feedback and recommendations for strengthening key cancer governance meetings from a systems and process perspective
5. **Undertake demand and capacity modelling for 2WW appointments and other key pathway milestones** – To ensure clear understanding of the capacity required for cancer pathways and identification of gaps with mitigating actions documented as part of an overall capacity plan for operations to own.

IST have made four visits to the Trust, most recently on 11th April where it was recognised and discussed with the IST Regional Manager that the Trust has made significant progress, aided by a full operational team being in place. IST reported the Trust has completed the Access Policy and had a comprehensive plan to deliver the RTT/Cancer training strategy through an external provider, this is currently in the negotiation phase for the

appropriate package in alignment with LWH systems. Work is on-going with other objectives however, the Trust were confident in using the tools required and had comprehensive plans in place to deliver this work.

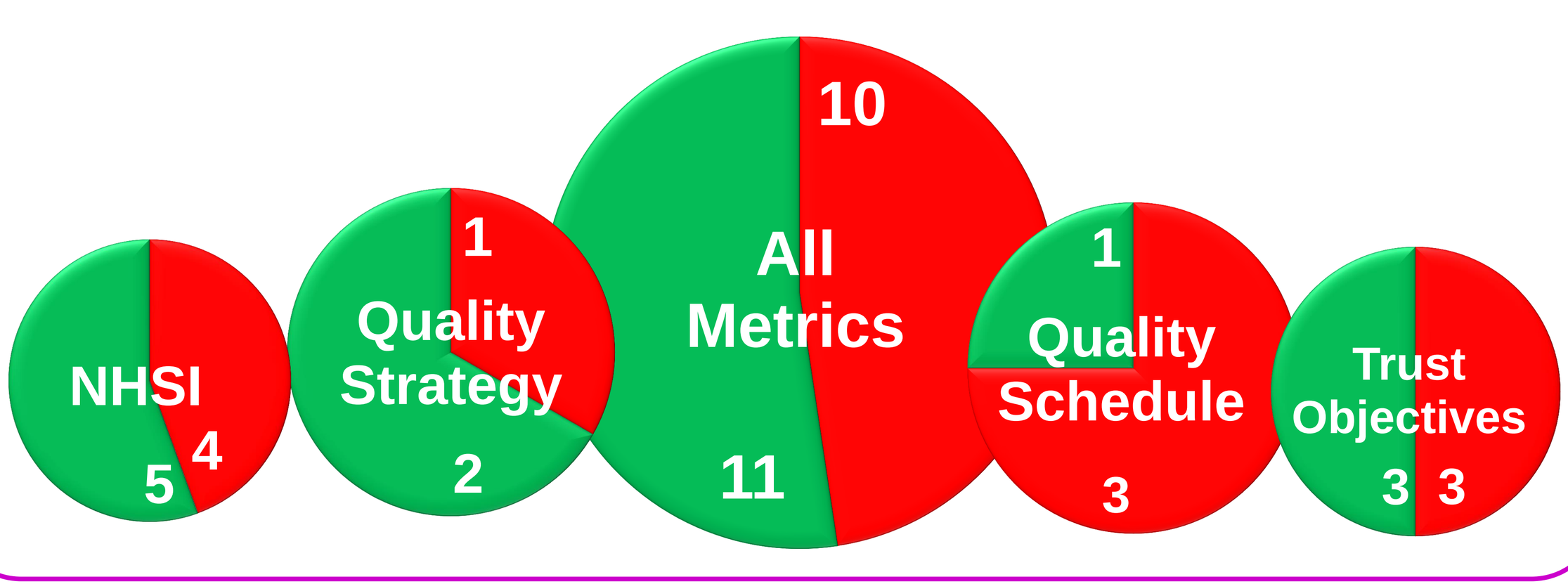
Due to progress made and the plans in place moving forward, IST have acknowledged that they would likely be recommending sign off to withdraw support from the Trust at the end of May 2019.

Appendix 1 – Scorecard

Performance and Information Department
Performance Team

Liverpool Women's NHS Foundation Trust

Performance Report for Trust Board — Month 12 - March 2019



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

Liverpool Women's NHS Foundation Trust

##

NHS Improvement 2018/19 Month 12 - March 2019

To be EFFICIENT and make the best use of available resources

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

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Target	Apr-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	0		0	1	0		0	0	0	
NHSE / NHSI Safety Alerts Outstanding	KPI193	Head of Governance	0	0	0	0		0	0	0		0	0	0		0	0	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%		5.2%	5.8%	5.6%	

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%	85.90%		85.48%	84.85%		
KPI003 Numerator				4137	4130	4238		4288	4312	4616		4522	4580	4551		4481	4626		
KPI003 Denominator				4627	4636	4827		4888	4988	5295		5192	5251	5298		5242	5452		
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%	66.67%		66.67%	*50.00%*		
KPI1031 Final Numerator				5.0	4.0	10.5		8.5	2.0	4.0		5.0	3.0	4.0		7.0	4.5		
KPI1031 Final Denominator				9.5	11.5	16.5		16.5	6.5	11.5		11.0	10.5	6.0		10.5	9.0		
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%	80.00%		58.33%	*47.37%*		
KPI1030 Final Numerator				5.0	4.0	10.5		12.5	2.0	4.0		5.0	3.0	4.0		7.0	4.5		
KPI1030 Final Denominator				9.5	12.0	18.5		20.5	7.0	11.5		13.5	13.0	5.0		12.0	9.5		
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Numbers (if > 5, the target applies)	KPI033 (EB13)	Access Turnaround Manager	< = 5	0	1	0		7	1	1		2	1	2		2	2		
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	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		9	7	10	

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**	**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%	5.2%	5.8%	5.6%
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**
18 Week RTT: Incomplete Pathway > 52 Weeks	KPI002 EBS4)	Head Of Operations Gynaecology	0	19	20	19	25	21	12	14	14	11	5	3	
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	229	232	260
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%	98.8%	93.7%	94.9%

LWH Quality Strategy 2018/19 LWH Quality Strategy

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

Key: TBA = To Be Agreed. TBC = To Be Confirmed, TBD = To Be Determined, ID = In Development

Indicator Name	CCG Ref	Owner of KPI	Target 2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sickness & Absence Rate	KPI101	Head of Workforce	<= 4.5%	4.52%	3.61%	4.34%	4.09%	4.27%	4.23%	3.63%	4.97%	5.0%	5.2%	5.8%	5.6%

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

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	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	9	7	10

Liverpool Women's NHS Foundation Trust

LWH Trust Objectives 2018/19 Month 12 - March 2019

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Deaths (All Live Births within 28 Days) All live births	KPI168	Clinical Director Neonates	< 6.1%	0.0%	0.42%	0.28%	0.13%	0.00%	0.56%	0.28%	0.44%	0.14%	0.14%	0.34%	0.15%
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%	0.15%	0.34%	0.15%

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	2	3	1

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	5.0	2	5	0	3.0	4	
18 Week RTT: Admitted	KPI001	Access Turnaround Manager	>= 90%	85.30%	90.64%	93.06%	92.96%	86.67%	86.69%	84.51%	80.89%	87.69%	75.43%	81.97%	
KPI1001 Numerator				412	465	416	436	455	456	420	381	342	304	291	
KPI1001 Denominator				483	513	447	469	525	526	497	471	390	403	355	
18 Week RTT: Non-Admitted	KPI004	Access Turnaround Manager	>= 95%	90.96%	94.55%	91.94%	90.68%	81.22%	88.47%	90.27%	89.82%	92.07%	90.26%	90.67%	
KPI1004 Numerator				1580	1684	1551	1742	1354	1450	1652	1817	1208	1834	1429	
KPI1004 Denominator				1737	1781	1687	1921	1667	1639	1830	2023	1312	2032	1576	

Agenda Item	2019/077

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	Finance Performance Review Month 12 2018/19
DATE OF MEETING:	Thursday, 02 May 2019
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	Claire Scott, Head of Management Accounts Eva Horgan, Deputy Director of Finance
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☐ 4. To participate in high quality research and to deliver the most *effective* outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☐ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services.* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care,* ☒

	supports learning and innovation, and promotes an open and fair culture. ***ALL DOMAINS*** ☐			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒		**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other:	
FREEDOM OF INFORMATION (FOIA):	3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the Month 12 Financial Position.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee		
	Date of meeting	23/04/2019		

Executive Summary

The 2018/19 Board-approved budget set out a control total deficit of £1.6m after the delivery of £3.7m CIP, and receipt of £3.6m Provider Sustainability Funding (PSF). The control total included £0.5m of agreed investment in the costs of the clinical case for change, in addition to £1.0m 2017/18 investment.

At Month 12 the Trust has bettered its control total and is reporting a full year surplus of £2.2m against a deficit budget of £1.6m, giving a full year favourable variance of £3.8m. This result was broadly in line with the previous months' forecast (of £0.6m deficit), before the inclusion of additional notified indicative income from the Provider Sustainability Fund.

The key areas of financial performance are summarised below.[1]

	Plan	Actual	Variance	RAG
Surplus/(Deficit) YTD	-£1.6m	£2.2m	£3.8m	↑
Provider Sustainability Fund (indicative)	£3.6m	£6.8m	£3.2m	↑
NHSI Rating	3	3	0	↔
Cash	£1.0m	£9.1m	£8.1m	↑
Total CIP Achievement YTD	£3.7m	£3.7m	£0.0m	↔
Recurrent CIP Achievement YTD	£3.7m	£1.7m	-£2.0m	↔
Capital Spend YTD	£12.5m	£9.2m	-£3.3m	↑

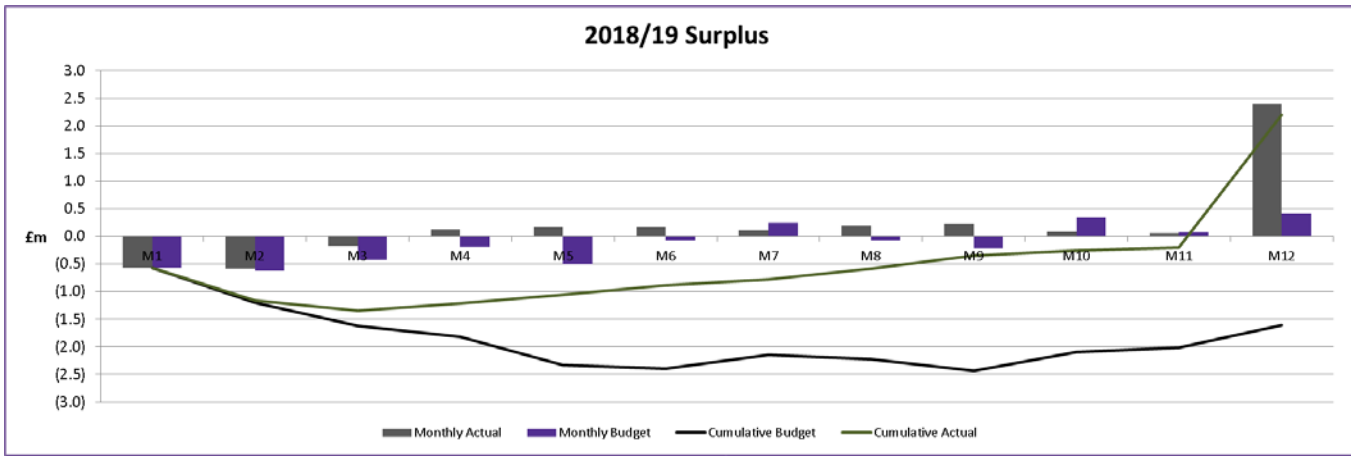
The annual accounts submission to NHSI is consistent with the content of this report.

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

Report

1. Summary Financial Position

At Month 12 the Trust is reporting a surplus of £2.2m for the full year against a deficit budget of £1.6m, which is £3.8m ahead of the agreed control total as outlined below. The control total now assumes receipt of £6.8m Provider Sustainability Funding (PSF) (including a £3.2m of bonus and incentive). This is subject to audit and finalisation of PSF by NHS Improvement.



Final 2018/19 position	
Planned Deficit*	(£1.6m)
Trust Improvement to control total	£0.55m
Bonus incentive PSF	£0.55m
Month 12 Reported Position	(£0.5m)
Additional PSF post year end	£2.7m
Month 12 Final surplus	£2.2m

*including £3.6m planned PSF

In 2018/19 the Trust continued 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 continued into 2018/19 with £4.6m additional income earned YTD to Month 12, than would have been earned under PbR.

Although recurrent CIP programmes were behind plan, non-recurrent mitigations were found and did not impact the achievement of the 2018/19 control total.

2. Divisional Summary Overview

Whilst the final trust-wide results were ahead of budget, there are areas of divisional performance which are behind plan.

Division of Family Health: Overall, the division was marginally overspent (£59k) for the full year. This was largely driven by income which was below plan in both directorates, even with the block adjustment benefitting Maternity. There were also as previously reported agreed pay overspends in Neonatal.

Division of Gynaecology: The division ended the year £2.5m behind plan, £1.7m relating to the Hewitt Fertility Centre and £0.7m relating to Gynaecology directorate (although the latter benefitted from nearly £2m of benefit through the block). There were also overspends on drugs and agency staff.

Division of Clinical Support: The division ended the year £284k overspent for the full year, largely relating to contracts and operational management.

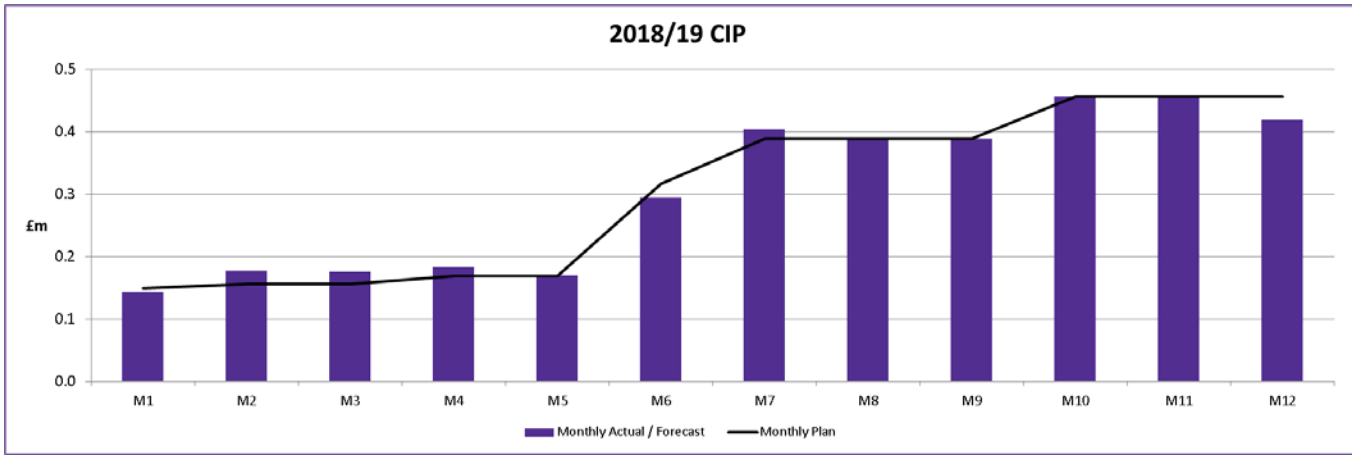
Corporate Services and Technical Items: Overall Corporate services finished the year well within plan, largely due to one off items or underspend on centrally held budgets.

Agency: Expenditure against agency staff remained within the limits set by NHSI, with £1.6m incurred against the £1.8m cap. This is above the £1.3m budget set internally, and increased in the latter months of the year, due to vacancies in the Finance department, Operational management, Gynaecology medical staff and Theatres.

A full review of the 2018/19 outturn was performed and factored into the 2019/20 budget setting process.

3. CIP

At Month 12 the Trust has delivered £0.4m against the in-month target of £0.4m, and has achieved full delivery of the £3.7m CIP, albeit with significant non-recurrent elements (£2m in the full year). The 2018/19 CIP was profiled in line with planned delivery and shows the target increasing throughout the year as follows.



The main areas of under-performance were primarily due to CNST Maternity Incentive (£1m), EPR slippage (£0.2m) and Gynaecology workforce (£0.3m). This has been offset by an anticipated £1.8m of non-recurrent underspends. (Note that the original plan contained £0.2m of non-recurrent schemes).

4. Contract Performance

Full year income was £4.6m higher than would have been received under PbR. This is driven by both Gynaecology and Maternity, but proportionately, Gynaecology has the most support from this arrangement.

£000	Month 12			YTD Block			
CCG	Block	Actual	Variance	Block	Actual	Variance	% Variance
Liverpool	3,715	3,436	-279	43,978	41,345	-2,633	-6.0%
Knowsley	629	524	-105	7,425	6,519	-905	-12.2%
South Sefton	915	738	-177	10,829	9,823	-1,006	-9.3%
Southport & Formby	111	92	-19	1,316	1,210	-105	-8.0%
Total	**5,370**	**4,789**	**-581**	**63,547**	**58,898**	**-4,650**	**-7.3%**

	Month 12			YTD Block			
Specialty	Block	Actual	Variance	Block	Actual	Variance	% Variance
Maternity	3,512	3,236	-277	42,019	39,594	-2,425	-5.8%
Gynae	1,622	1,340	-282	18,680	16,704	-1,976	-10.6%
Imaging	15	11	-4	168	151	-17	-10.3%
HFC	221	202	-18	2,680	2,449	-231	-8.6%
Total	**5,370**	**4,789**	**-581**	**63,547**	**58,898**	**-4,650**	**-7.3%**

Note that the Trust has secured a block arrangement with Liverpool, South Sefton and Southport & Formby for 2019/20, but not for Knowsley, which remains as PbR. This block has been re-set using forecast out-turn but after tariff improvements and negotiating higher payments in some areas, the level of income is actually higher than in 2018/19 on a like for like basis. However there is a greater degree of risk (or potential benefit) related to Knowsley activity.

5. Cash and Borrowings

The cash balance at year end was £9.1m compared to a 2017/18 year end position of £6.0m and is ahead of plan, due to the improved I&E position and higher than anticipated creditors and accruals.

Total borrowings have increased to £13.6m, reflecting the drawdown of the neonatal build loan.

The Trust received in March the full £1.6m Public Dividend Capital related to achievement of the milestones on the Global Digital Exemplar Fast Follower programme.

The Trust had a planned operational cash borrowing requirement of £1.6m for 2018/19, however there was no requirement for a cash drawdown in year.

6. Capital Expenditure

Of the total £12.5m capital plan, £9.3m has been spent in the full year, primarily on GDE Fast Follower infrastructure and implementation costs. The slippage is predominantly due to timing differences in the neonatal build plans. A total of £3.7m has now been spent YTD on the Neonatal Redevelopment, which has been covered by loan drawdown.

7. Balance Sheet

Creditors are higher than at year end, primarily due to the Trust paying down creditors at 2017/18 year end and an expected increase in-year. Creditors have also been impacted by the movement to an upgraded ledger which has led to some delays in processing. A focus remains on recovery of debt, and debtors are significantly lower than at 2017/18 year end position (before PSF).

As reported to the Audit Committee in March, 2019 provisions were reviewed at year end.

8. BAF Risk

The Trust achieved its control total (subject to audit) and target risk score of 10 in relation to delivery of the financial position in year. This risk will be re-assessed against the 2019/20 plan and reset to the inherent risk of 25 to reflect the increased risk at the start of each financial year.

9. Conclusion & Recommendation

The Board are asked to note the year end financial position (which is subject to audit and finalisation of PSF by NHSI).

Appendix 1 – Board Pack

Board Finance Pack
M12 - Board Final

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M12

YEAR ENDING 31 MARCH 2019

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M12
YEAR ENDING 31 MARCH 2019

USE OF RESOURCES RISK RATING	YEAR Budget	YEAR Actual
CAPITAL SERVICING CAPACITY (CSC)		
(a) EBITDA + Interest Receivable	5,053	8,641
(b) PDC + Interest Payable + Loans Repaid	2,684	7,994
CSC Ratio = (a) / (b)	**1.88**	**1.08**
NHSI CSC SCORE	**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	(2,385)	(10,457)
(b) Expenditure	111,627	110,460
(c) Daily Expenditure	306	303
Liquidity Ratio = (a) / (c)	**(7.8)**	**(34.6)**
NHSI LIQUIDITY SCORE	**3**	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)		
I&E MARGIN		
Deficit (Adjusted for donations and asset disposals)	(1,601)	2,149
Total Income	116,656	119,044
I&E Margin	**-1.4%**	**1.8%**
NHSI I&E MARGIN SCORE	**4**	**1**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)		
I&E MARGIN VARIANCE FROM PLAN		
I&E Margin (Actual)		1.80%
I&E Margin (Plan)		-1.40%
I&E Variance Margin	**0.00%**	**3.20%**
NHSI I&E MARGIN VARIANCE SCORE	**1**	**1**
Ratio Score 1 = 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%		

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

AGENCY SPEND		
YTD Providers Cap	1,805	1,805
YTD Agency Expenditure	1,284	1,634
	-28.9%	**-9.5%**
NHSI AGENCY SPEND SCORE	**1**	**1**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%		
Overall Use of Resources Risk Rating	**3**	**3**

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M12
YEAR ENDING 31 MARCH 2019

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR Budget	YEAR YTD	YEAR Variance
Income						
Clinical Income	(9,135)	(8,373)	(763)	(106,086)	(103,801)	(2,285)
Non-Clinical Income	(1,007)	(4,330)	3,323	(10,570)	(15,262)	4,692
Total Income	**(10,142)**	**(12,702)**	**2,560**	**(116,656)**	**(119,063)**	**2,407**
Expenditure						
Pay Costs	5,775	4,598	1,177	69,491	66,128	3,363
Non-Pay Costs	2,256	3,985	(1,728)	27,868	29,049	(1,181)
CNST	1,128	1,275	(147)	14,268	15,299	(1,031)
Total Expenditure	**9,159**	**9,857**	**(698)**	**111,627**	**110,476**	**1,151**
EBITDA	**(983)**	**(2,845)**	**1,862**	**(5,029)**	**(8,587)**	**3,558**
Technical Items						
Depreciation	395	399	(4)	4,586	4,721	(135)
Interest Payable	37	7	30	356	227	129
Interest Receivable	(2)	(7)	5	(24)	(57)	33
PDC Dividend	143	102	41	1,716	1,544	172
Profit / Loss on Disposal	0	(8)	8	0	(8)	8
Total Technical Items	**573**	**494**	**79**	**6,634**	**6,427**	**207**
(Surplus) / Deficit	**(410)**	**(2,351)**	**1,941**	**1,605**	**(2,160)**	**3,765**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M12
YEAR ENDING 31 MARCH 2019

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR Budget	YEAR YTD	YEAR Variance
Pay Costs						
Board, Execs & Senior Managers	361	772	(411)	4,331	4,489	(158)
Medical	1,377	1,740	(363)	16,521	16,358	163
Nursing & Midwifery	2,465	2,201	265	29,768	28,479	1,289
Healthcare Assistants	390	398	(8)	4,690	4,650	41
Other Clinical	558	(1,142)	1,700	6,696	4,742	1,954
Admin Support	168	159	8	2,013	1,906	106
Corporate Services	349	208	141	4,187	3,873	315
Agency & Locum	107	262	(155)	1,285	1,632	(347)
Total Pay Costs	**5,775**	**4,598**	**1,177**	**69,491**	**66,128**	**3,363**
Non Pay Costs						
Clinical Suppplies	751	1,233	(482)	8,930	9,678	(748)
Non-Clinical Supplies	492	933	(441)	6,009	6,184	(175)
CNST	1,128	1,275	(147)	14,268	15,299	(1,031)
Premises & IT Costs	392	371	21	5,303	5,922	(618)
Service Contracts	622	1,448	(826)	7,626	7,265	361
Total Non-Pay Costs	**3,384**	**5,260**	**(1,875)**	**42,136**	**44,348**	**(2,212)**
Total Expenditure	**9,159**	**9,857**	**(698)**	**111,627**	**110,476**	**1,151**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M12
YEAR ENDING 31 MARCH 2019

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR Budget	YEAR YTD	YEAR Variance
Maternity						
Income	(4,019)	(4,130)	111	(47,997)	(47,554)	(443)
Expenditure	1,800	1,900	(100)	21,591	21,049	543
Total Maternity	**(2,218)**	**(2,230)**	**11**	**(26,406)**	**(26,505)**	**99**
Neonatal						
Income	(1,369)	(1,361)	(7)	(16,388)	(16,200)	(188)
Expenditure	1,024	1,044	(20)	12,276	12,246	30
Total Neonatal	**(344)**	**(317)**	**(27)**	**(4,112)**	**(3,954)**	**(158)**
Division of Family Health - Total	**(2,563)**	**(2,547)**	**(16)**	**(30,518)**	**(30,459)**	**(59)**
Gynaecology						
Income	(2,278)	(2,489)	212	(26,139)	(25,814)	(325)
Expenditure	876	1,114	(239)	10,659	11,065	(406)
Total Gynaecology	**(1,402)**	**(1,375)**	**(27)**	**(15,480)**	**(14,749)**	**(732)**
Hewitt Centre						
Income	(947)	(762)	(185)	(10,555)	(9,454)	(1,101)
Expenditure	637	795	(158)	7,627	8,265	(637)
Total Hewitt Centre	**(310)**	**33**	**(343)**	**(2,928)**	**(1,189)**	**(1,739)**
Division of Gynaecology - Total	**(1,712)**	**(1,342)**	**(369)**	**(18,408)**	**(15,938)**	**(2,470)**
Theatres						
Income	(39)	(39)	0	(467)	(471)	4
Expenditure	675	635	40	8,088	7,795	293
Total Theatres	**636**	**596**	**40**	**7,621**	**7,324**	**297**
Genetics						
Income	(605)	(638)	33	(7,246)	(7,357)	111
Expenditure	473	749	(275)	5,680	6,000	(320)
Total Genetics	**(131)**	**111**	**(242)**	**(1,565)**	**(1,356)**	**(209)**
Other Clinical Support						
Income	(30)	(28)	(2)	(330)	(313)	(17)
Expenditure	733	1,031	(298)	8,987	9,342	(355)
Total Clinical Support & CNST	**703**	**1,003**	**(300)**	**8,657**	**9,029**	**(372)**
Division of Clinical Support - Total	**1,208**	**1,710**	**(502)**	**14,712**	**14,996**	**(284)**
Corporate & Trust Technical Items						
Income	(857)	(3,254)	2,397	(7,534)	(11,901)	4,367
Expenditure	3,513	3,083	431	43,353	41,142	2,211
Total Corporate	**2,657**	**(171)**	**2,828**	**35,819**	**29,241**	**6,578**
(Surplus) / Deficit	**(410)**	**(2,351)**	**1,941**	**1,605**	**(2,160)**	**3,765**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
CIP: M12
YEAR ENDING 31 MARCH 2019

SCHEME	MONTH 12 TARGET	MONTH 12 ACTUAL	MONTH 12 VARIANCE	YEAR TARGET	YEAR YTD	YEAR VARIANCE
Legal Premium Reduction	147	0	(147)	1,030	0	(1,030)
Patient Flow & Demand	16	13	(3)	95	49	(46)
Service Development Income	11	5	(6)	124	52	(71)
Service Development Non Pay	49	31	(18)	482	371	(111)
Service Development Pay	34	4	(29)	240	50	(191)
System & Environmental Income	7	6	(1)	73	69	(5)
System & Environmental Non Pay	20	21	1	147	195	48
Technology	94	27	(67)	515	310	(206)
Workforce	80	62	(18)	949	733	(216)
Non-recurrent Mitigation	0	250	250	0	1,826	1,826
TOTAL	**457**	**419**	**(38)**	**3,656**	**3,656**	**0**

*Scheme names as per NHSI return

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M12
YEAR ENDING 31 MARCH 2019

BALANCE SHEET £'000	YEAR TO DATE Opening	M12 Actual	Movement
Non Current Assets	**76,313**	**79,968**	3,655
Current Assets			
Cash	6,013	9,066	3,053
Debtors	8,407	6,438	(1,969)
Inventories	452	489	37
Total Current Assets	**14,872**	**15,993**	**1,121**
Liabilities			
Creditors due < 1 year	(11,257)	(17,270)	(6,013)
Creditors due > 1 year	(1,686)	(1,654)	32
Loans	(17,221)	(13,635)	3,586
Provisions	(4,514)	(3,962)	552
Total Liabilities	**(34,678)**	**(36,521)**	(1,843)
TOTAL ASSETS EMPLOYED	**56,507**	**59,440**	**2,933**
Taxpayers Equity			
PDC	38,451	40,088	1,637
Revaluation Reserve	15,367	14,503	(864)
Retained Earnings	2,689	4,849	2,160
TOTAL TAXPAYERS EQUITY	**56,507**	**59,440**	**2,933**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M12
YEAR ENDING 31 MARCH 2019

CASHFLOW STATEMENT	YEAR TO DATE		
£'000	Budget	Actual	Variance
Cash flows from operating activities	443	3,865	3,422
Depreciation and amortisation	4,586	4,721	135
Movement in working capital	(4,036)	6,325	10,361
Net cash generated from / (used in) operations	**993**	**14,911**	**13,918**
Interest received	24	55	(31)
Purchase of property, plant and equipment and intangible assets	(12,554)	(8,142)	(4,412)
Proceeds from sales of property, plant and equipment and intangible assets	0	8	(8)
Net cash generated from/(used in) investing activities	**(12,530)**	**(8,079)**	**(4,451)**
PDC Capital Programme Funding - received	1,600	1,637	(37)
Loans from Department of Health Capital - received	6,000	2,625	3,375
Loans from Department of Health Capital - repaid	(612)	(612)	0
Loans from Department of Health Revenue - received	1,601	0	1,601
Loans from Department of Health Revenue - repaid	0	(5,600)	5,600
Interest paid	(349)	(237)	(112)
PDC dividend (paid)/refunded	(1,716)	(1,592)	(124)
Net cash generated from/(used in) financing activities	**6,524**	**(3,780)**	**10,304**
Increase/(decrease) in cash and cash equivalents	**(5,013)**	**3,053**	**(8,066)**
Cash and cash equivalents at start of period	6,013	6,013	0
Cash and cash equivalents at end of period	**1,000**	**9,066**	**(8,066)**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding at M12
Loans from Department of Health Capital (ITFF)- 2.0% Interest Rate	5,500	(2,140)	3,360
Loans from Department of Health Capital (Neonatal)- 2.54% Interest Rate	3,625	0	3,625
Loans from Department of Health Revenue - 1.50% Interest Rate	14,612	(7,962)	6,650
Total	**23,737**	**(10,102)**	**13,635**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M12
YEAR ENDING 31 MARCH 2019

CAPITAL EXPENDITURE £'000	Year to Date Budget	Year to Date Actual	Year to Date Variance
Neonatal New Building	6,968	3,706	3,262
Other Building Projetcs	293	325	(32)
Estates & Environmental Projects	441	382	59
Global Digital Examplar Fast Follower & IM&T Projects	3,200	3,252	(52)
Medical Equipment	1,418	1,359	59
Other	222	204	18
Total	**12,542**	**9,228**	**3,314**

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	2019/079

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Corporate Objectives 2018/19 Annual Review and Corporate Objectives 2019/20**
DATE OF MEETING:	Thursday, 02 May 2019
ACTION REQUIRED	**For Approval**
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:-….)***	***The Board is asked to note and agree: the performance for the year against the Corporate Objectives 2018/19; and the Corporate Objectives 2019/20.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		***Choose an item.*** SEE BELOW ***Click here to enter text.***	
	Date of meeting		***Click here to enter a date.***	

Report

The Board of Directors reviewed the corporate objectives 2018/19 at its meeting on 6 April 2018 and formally approved them on 2 May 2018.

The Board agreed that each Board Committee would review the performance of the Trust against those objectives that they are aligned to within its terms of reference and also agree the objectives for 2019/20.

Following review of performance against the corporate objectives 2018/19 and approval of the Corporate Objectives 2019/20 by each of the Board Committees, the objectives would be brought together and presented to the Board for approval at its meeting on 2 May 2019.

Corporate Objectives reviewed dates by Committee:

- Finance Performance and Business Development Committee on 25 March 2019
- Quality Committee on 25 March 2019
- Putting People First Committee on 23 April 2019

<u>Recommendation</u>

The Board is asked to note and agree: the performance for the year against the Corporate Objectives 2018/19; and the Corporate Objectives 2019/20.

STRATEGIC AIMS AND OUR CORPORATE OBJECTIVES 2018/19

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

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

Corporate Objective To develop a WELL LED, capable, motivated and entrepreneurial Workforce;	Executive Lead	Relevant Strategy	Board Committee	Annual review
Improving the Health & Wellbeing of the workforce by moving to upper quartile performance for % sickness absence and stress related absence incrementally between 2018-2021 as measured by the Annual Staff Survey	DoW&M	People Strategy	Putting People First	From the 2018 staff survey results, 2out of 3 HWB scores have shown an improvement from 2017 Question 19a "Does your Trust take HWB seriously?": 32.3% up from 28.1% (Specialist Acute Trusts (SAT) 33.6%, Acute Trusts (AT) 27.8%) and against a nationally declining score Question 19b "Have you suffered an MSK injury in the last year?": 19.7% increased from 15.7% (SAT24.5%, AT 28.7%) Question 19c "Have you experienced work related stress in the last year?" 32% down from 33.5% (SAT 35.9%, AT 38.9%) *Additional actions* "How Are You Feeling Today?" Programme commenced based on NHS Employers' model to understand when high levels of pressure are occurring in teams Commenced NHSI sickness project and a multidisciplinary steering group is reviewing all aspects of sickness management and making recommendations. Trained 56 Mental Health first Aiders to identify and take action in their local areas. We continue to increase our numbers through our internal training programme and are looking to develop the offer over the coming year. Re-negotiating contracts with Merseycare for staff support services and physiotherapy with slightly increased provisions that will allow those services to provide targeted pro-active sessions out in the departments Implementation of FITECH in specific departments (this is a diagnostic tool that helps staff understand about stress and resilience) 18/19 sickness rates – as at end of February the cumulative sickness absence rate for the Trust is 4.60% (slightly above the target figure of 4.50%) Freedom to Speak Up Guardian service actively promoted and known to staff Additional workshops to support managers delivered to help their staff include Resilience for Managers and

				Health and Wellbeing for Managers. Fair & Just Culture Programme – Y1 objectives rolled out
Improving the organisation's climate and increasing the overall staff engagement score (as measured by Annual Staff Survey & the Staff Friends & Family Test) to upper quartile for acute specialist Trusts incrementally between 2018-2021	DoW&M	People Strategy	Putting People First	Go Engage launched & generating team level data for managers National Staff Survey Engagement score maintained Board Listening Events Programme implemented & evaluated highly by staff 100 days in post – implemented Organisational restructure implemented with increased divisional accountability/autonomy NHSI Retention Project underway, with particular focus on N&M Development programmes in place – including Leadership Programme, Aspirant Talent Programme, & new Medical Leaders (in-house) and National Leadership programmes accessed (externally) People Strategy approved by Board 1.2.19
Expanding the Trust's reach into its communities through extending its work experience, work training, guaranteed interview and apprenticeship schemes	DoW&M	People Strategy	Putting People First	160 Work Experience placements offered in year with universally positive feedback received. This meets HEE targets Careers Events delivered to local school students, most recently in November 2018, giving them a taste of hospital life, and Trust staff participate in community careers fairs on a regular basis. Secured funding from Health Education England to support 25 people on schemes to help them into work. The first cohort of 14 pre-employment participants completed in October with one person gaining permanent employment, 2 fixed term positions, 5 bank workers, one volunteer, and one person has now gained sufficient confidence to seek permanent work elsewhere. Second programme to commence in 2019-20 Cadet programme developed with launch in September with support from the Nursing Directorate. Employers Award from Southport College for Partnership Working 25 posts have been offered to date as apprenticeships, and although this does not meet our Public Sector Duty target of 31, we have a 5 year period over which to achieve this. All appropriate posts are promoted as potential apprenticeships and this is built into our vacancy control process. . Plans in development to commence Nursing Associate Training through apprenticeships along with opportunities for Advanced Clinical Practitioners and OPDs Annual Members Meeting refreshed approach with positive feedback Get Involved campaign – initial event resulted in 50 new members for the Trust

Shaping workforce to meet operational needs through effective workforce planning and partnerships	DoW&M	People Strategy	Putting People First	Cadet Programme in development Strategic Workforce Group actively overseeing development of extended roles Joint consultant appointments – Alder Hey, RLUBHT Neonatal Surgical Single Service – staffing model developed Talent Management processes strengthened and managers supported with their talent management/succession planning. Further review & actions in 19/20 in response to identified ageing nursing workforce

Corporate Objective To be ambitious and Efficient and make best use of available resources	Executive Lead	Relevant Strategy	Board Committee	Annual review
Deliver the financial plan for 2018/9	DoF	Operational Plan 18/19	Finance, Performance and Business Development	The deficit control total of £1.6m was planned to be achieved through making a deficit of £2.4m in M1-M6 and a surplus of £0.8m in M7-M12. The more favourable position in the second half of the year was primarily related to CIP phasing and in particular the CNST Incentive. At month 11 the Trust is planning to deliver in excess of the control total and attract additional Provider Sustainability Funding (PSF) in relation to this. There was no cash drawdown required. This objective has been achieved.
Deliver the operational plan for 2018/9	DoO	Operational Plan 18/19	Finance, Performance and Business Development	Gynaecology has seen a number of significant challenges in terms of the SUI's declared in February 2018 in respect to 18 weeks RTT and Cancer targets. Then a significant reduction in capacity caused by consultants vacancies and long term sickness which has delayed recovery of national access targets. Progress has been made in appointment of additional General gynaecology and Oncology consultants. Overall, this has impacted the services ability to achieve the CCG contracted activity plan; this has been reviewed as part of the "right sizing project" for the 2019/20 operational plan. The Gynaecology emergency room merged with the Maternity assessment Unit in the evenings as a test pilot for a potential full merger, however this was not taken forward.

				Maternity activity has reduced as anticipated and is expected to have deliveries in the region of 8200 (2017/18 8600). The service has reduced costs in terms of pay and non-pay and has also reviewed service income and costs as part of the "right size project". Community midwifery services have been reviewed as per "Better Births" and a plan to transform services is now in place. Genetic services have successful bid in Partnership with services in the Northwest to win the laboratory services for this area. Central Manchester are the lead provider and a mobilisation plan is being developed to meet the NHSE timeframes for full implementation. Plans are being developed in partnership to TUPE staff to the lead provider in Q1 19/20. Neonatal services have agreed a MOU with Alder Hey for a single Neonatal Service, have submitted a business case to NHSE and have started implementation of the plans. Governance arrangements have been established. The £15M extension has completed the design phase and the GMP has been agreed, building work has commenced with a completion date for July 2020.
Demonstrate the effective use of resources in providing high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review of Operational productivity and current National initiatives (Model Hospital/GIRFT)	DoF	Operational Plan 18/19	Finance, Performance and Business Development	Benchmarking work is well underway and the Trust is engaged in the STP/H&CP Carter Work stream. This has underpinned the Trust's review of CIP and control total achievability moving into 19/20 and will continue to be a feature going forward.

Corporate Objective To deliver Safe services	Executive Lead	Relevant Strategy	Board Committee	Annual review
Maintain regulatory confidence & compliance	CEO	All	All	The Trust continually keeps NHSI and CQC up to date with developments within the Trust and confidence in management and compliance is high. Regular monthly meetings with NHSI on matters pertaining to the Trust's financial position and future Generations is ongoing. Recognition that the Trust is doing all things necessary to delivery sustainable services. Achieved Overall 'Good' rating following CQC inspection in February 2018 Monthly and annual submissions to NHSI completed within timeframes set Annual Report and Accounts 2017/18 submitted to Parliament within required timeframes. Acceptance of 19/20 control total proposed
Successfully delivering year 1 of the Neonatal new build	MD/DoO /DoF	Future Generations	Finance, Performance and Business Development	The program remains on track. The Guaranteed Maximum Price has been agreed and works have begun. A plan to minimise disruption of clinical activities in the Neonate and the rest of the trust is in place.
Delivery of in year Quality Strategy objectives	MD/ DoN&M	Quality Strategy	Quality	The Trust has completed the second year of the 2017/2020 Quality Strategy. The strategy objectives continue to be monitored on a quarterly basis via the Quality Committee. Progress has been good throughout the nine key identified areas of activity. In the final year to achieve all objectives, a focus will be required on the readmission of patients to hospital and/or to the operating theatres. A plan has been formulated to deliver against these objectives, including input from the gynaecological clinical leads.
Working in partnership with providers and commissioners to ensure quality safe services are delivered to the population of the region. This will include working closely with the following :- • Cheshire and Merseyside Partnership (STP) to develop and influence	DoO	Operational Plan	All	The Cheshire and Merseyside Women's and Children's Partnership agreed in Octobers 2018 meeting to provide a resolution to the STP that the LWH strategic case was fully supported by the partnership. The Northwest Genetics Partnership has been successful in its bid to be the Northwest Genetic Hub. The mobilisation plan is currently being developed and key staff from LWH are influencing at every level. Neonatal services have agreed a MOU with Alder Hey for a single Neonatal Service, have submitted a business case to NHSE which is partly approved and have started implementation of the plans. Governance arrangements have been established. Regular meetings with the Director for the Neonatal ODN has ensured high levels of support with regard to assuring the commissioners NHSE of the partnerships plans.

regional strategy • North West Genetics Partnership - for the tender for genetics services • Alder Hey to implement the Neonatal Single Service on two sites				
Electronic Patient Records project delivery and implementation with required timeframe • To ensure that the modules provided in the new EPR are fit for clinical purpose • To ensure the services are fully prepared to continue delivering services as usual when the new EPR system goes live. • Finance - Deliver the technical solution within the agreed budget	MD DoO DoF	EPR Project Plan	Finance, Performance and Business Development	The EPR project is a three-trust plan to introduce an electronic recording system which would work seamlessly across the three organisations – LWH, RLBUHT and AUHT. The Program has faltered predominantly due to design and build issues which have arisen for reasons that sit with the supplier, thus, largely out of the control of the three trusts. These have been reported through Digital Hospital Committee and up to Finance, Performance and Business Development at LWH. They are also the focus of work for the Programme Board, which meets monthly. At present, use of a more advanced platform has been proposed by the supplier which will better be able to cope with the key area of concern, around prescribing and administering medicines. In the coming months, a critical eye will be kept on that area of activity and significant assurances sought. The program has failed to deliver the CIP target and will fail in 19/20. Despite executive oversight and scrutiny, none of the three sub-points within the objective can be demonstrated. This has been discussed and reviewed in a number of fora. The Trust will need to consider going forward whether, given the lack of progress, this project in its current form is deliverable.
Maintain Safe Staffing levels	DoNM	Quality & People Strategies	Putting People First	Assurance on staffing levels regularly provided to PPF and Board around Safe Staffing levels No significant recruitment issues or vacancy factors in nursing & midwifery Proactive recruitment processes in place (Job Fairs etc) Headroom reviewed & increased

Corporate Objective To participate in high quality research in order to deliver the most Effective outcomes	Executive Lead	Relevant Strategy	Board Committee	Annual review
Develop closer working relationships with University of Liverpool with respect to research and innovation	MD	R&D	Quality	Liverpool Health Partners is on the verge of opening its Joint Research Service (JRS) bringing together all Trust and HEI RD&I departments, including those from LWH. This is a major step forward. 'Women and Children' now form a key focus of activity for LHP. This has been illustrated by the Starting Well workstream, which is being lead by clinicians from both AHUH and LWH under the LHP umbrella. The University of Liverpool has also recently reviewed its own research priorities and a strong Women and Children's theme is emerging.
Successful implementation of the Trust's Research and Development Strategy to enhance the Research and Innovation capabilities of the Trust	MD	R&D	Quality	Work towards implementation of the Trust's Research and Development strategy has been ongoing throughout 2018/19 and progress has been submitted to the Quality Committee on schedule by way of scheduled formal reports. There has been an ongoing investment of PAs to consultants in the Trust with an interest in R&D. R&D leadership within the nursing and midwifery workforce remains under review in line with the R&D strategy.

Corporate Objective To deliver the best possible Experience for patients and staff	Executive Lead	Relevant Strategy	Board Committee	Annual review
Providing a patient led experience, continuously seeking feedback to further enhance our service provision.	DoN&M	Patient Experience Strategy	Quality	The Trust launched it new Patient Experience Strategy in the Summer of 2018. Within this new strategy for 2018-2021 there are 5 new always events which have been generated with patient and public feedback. This will be monitored through patient experience committee To increase patient feedback as part of Friends and Family the Head of Patient experience and IT have developed a text alert system for patient to be able to provide feedback on line to the Trust rather than just eh card system in place. The first wave of this new process is schedule to be rolled out the beginning of December 2018. This will also be monitored via patient experience committee and also by the CCG at CQPG. Regular monitoring and review of trends and themes form patient complaints and PALs contacts are provided

				to PPF and to the Quality committee to ensure that we are able to put actions in place in response to a trends or themes. Reports are now completed in relation to the collation of themes and trends form PALs+ meetings to ensure all divisions receive appropriate feedback to enable the development of action plans.

Corporate Objective Delivery of the Future Generations Strategy	Executive Lead	Relevant Strategy	Board Committee	Annual review
Support Commissioners and Regulators to agree strategic direction for Trust services, commencing with public consultation and Commissioner Decision Making Business Case.	CEO	Future Generations	Board specific	Clinical review of standards undertaken issues identified that quantified issues and risks of remaining on an isolated site. Issues relating to the skills and age profile of the consultant body have also been explored; this has highlighted the need for a move, more decisively, to a multidisciplinary hospital site within 5-10 years. Commissioner support retained despite lack of success in STP Capital bid, with plans for a way forward being developed. A refreshed SOC will be produced by summer 2019 and clinical summit will be held in June 19 to inform next steps
Work jointly with other providers and regulators to consider options for future collaborations and organisational form.	DoF	Future Generations	Board specific	Collaboration has continued, with relationships with STP strengthened following a change in leadership. Despite being ranked first of the C&M large schemes and third overall the Trust was not successful in its STP capital bid nationally. A plan to take the case forward is being developed (see above) NHSI are reluctant to allow the Trust to address organisational form in the near future but the dialogue remains open. Dialogue is ongoing with NHSE, MPs, councillors and other stakeholders to ensure the case for change is well understood
Retain Public and Staff Confidence through an effective Communications and Engagement Strategy	DoW&M	Future Generations	Board specific	The Future Generations communications plan was updated in 2017/18 to cover the period 2017-20. The revised communications plan acknowledged that with limited progress on a move to public consultation and a decision on the future of Liverpool Women's services, the focus needed to shift to a series of simple, clear and effective key messages which reassure all stakeholders including patients, visitors and staff. A series of key messages were produced and continue to be consistently referred to – these messages are

				broadly; We are not closing, we want to make our services better for the future, our staff have shaped our plans for the future, and any potential move to a new hospital will be some time away which means we will be on our current site for a number of years to come. These key messages have been and will continue to be referred to at regular intervals for both consistent messaging and also at times of significant interest such as during any political periods where the future of Liverpool Women's is being discussed, or when any developments take place relating to a potential public consultation. Recent developments of note where these key messages were used occurred during September 2018 in advance of the Labour Party Conference. The Trust referred to the key messages to counter a planned demonstration against the plans for the future by a local campaign group. The Trust's key messages received significant media, online, social media and public exposure with an overall average reach/audience for TV/radio/printed news of over 410k and an average reach/audience for LWH social media and website posts of almost 40k. The impact of the demonstration march was perceived to be less than the campaign group's previous activities due to our proactive factual messaging and anecdotally the Trust feels that stakeholder understanding about our future is now more clearly understood as a result. Positive publicity for the clinical case from the Hospital program on BBC 2

Liverpool Women's NHS Foundation Trust

STRATEGIC AIMS AND CORPORATE OBJECTIVES 2019/20

By Committee

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

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

Corporate Objective To develop a WELL LED, capable, motivated and entrepreneurial Workforce;	Executive Lead	Relevant Strategy	Board Committee
Improving the Health & Wellbeing of the workforce by moving closer to upper quartile performance for % sickness absence and stress related absence incrementally between 2019-2021 as measured by the Annual Staff Survey	DoW&M	People Strategy	Putting People First
Improving the organisation's climate and increasing the overall staff engagement score (as measured by Annual Staff Survey & the Staff Friends & Family Test) to upper quartile for acute specialist Trusts incrementally between 2019-2021	DoW&M	People Strategy	Putting People First
Expanding the Trust's reach into its communities through extending its widening participation, work experience, work training, guaranteed interview and apprenticeship schemes with all areas of the Trust being active partners to the programme	DoW&M	People Strategy	Putting People First
Shaping workforce to meet operational needs through effective workforce planning , recruitment & retention strategies and innovative partnerships	DoW&M	People Strategy	Putting People First

Corporate Objective To be ambitious and Efficient and make best use of available resources	Executive Lead	Relevant Strategy	Board Committee
Deliver the financial plan for 2019/20	DoF	Operational Plan 19/20	Finance, Performance and Business Development
Deliver the operational plan for 2019/20	DoO	Operational Plan 19/20	Finance, Performance and Business Development
Demonstrate the effective use of resources in providing high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review of Operational productivity and current National initiatives (Model Hospital/GIRFT)	DoF	Operational Plan 19/20	Finance, Performance and Business Development

Corporate Objective To deliver Safe services	Executive Lead	Relevant Strategy	Board Committee
Maintain regulatory confidence & compliance	CEO	All	All
Delivery of in year Quality Strategy objectives	MD/ DoN&M	Quality Strategy	Quality

Successfully delivering year 2 of the Neonatal new build	MD/DoO/DoF	Future Generations	Finance, Performance and Business Development
Working in partnership with providers and commissioners to ensure quality safe services are delivered to the population of the region. This will include working closely with the following :- • Cheshire and Merseyside Partnership (STP) to develop and influence regional strategy • Liverpool CCG in supporting the Place plans • North West Genetics Partnership - implementing the changes genetics services • Alder Hey to implement the Neonatal Single Service on two sites	DoO	Operational Plan	Finance Performance and Business Development
Electronic Patient Records project delivery and implementation with required timeframe • Dependant on outcome discussions	DoF/MD/DoO	EPR Project Plan	Finance, Performance and Business Development/ Quality Committee
Working in partnership with providers and commissioners to ensure quality safe services are delivered to the population of the region. This will include working closely with the following :- • Cheshire and Merseyside Partnership (STP) to develop and influence regional strategy • North West Genetics Partnership - for the tender for genetics services • Alder Hey to implement the Neonatal Single Service on two sites	DoO	Operational Plan	All
Develop IM&T as a strategic enabler ensuring that clinical systems are fit for purpose, forward focussed and embrace the wider strategic view of the health economy	DoF	IT Strategy	Finance Performance and Business Development
Deliver the objectives defined in the Trust LocSSIP Group's Terms of Reference	MD	Quality Strategy	Quality
Maintain Safe Staffing levels	DoN&M	Quality & People Strategies	Putting People First
To implement the in-year objectives of the Fair & Just Culture Programme	DoW&M	People Strategy	Putting People First

Corporate Objective To participate in high quality research in order to deliver the most Effective outcomes	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Develop closer working relationships with University of Liverpool with respect to research and innovation	MD	R&D	Quality

Successful implementation of the Trust's Research and Development Strategy to enhance the Research and Innovation capabilities of the Trust	MD	R&D	Quality

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

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

Agenda Item	**2019/080**

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Compliance with Provider Licence Condition General Condition 6 & Continuity of Services 7**
DATE OF MEETING:	Thursday, 02 May 2019
ACTION REQUIRED	**For Approval**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance Colin Reid Trust Secretary
AUTHOR(S):	**Click here to enter text.**
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *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	☒	**4.** NHS Constitution	☐
	2. Operational Plan	☐	**5.** Equality and Diversity	☐
	3. NHS Compliance	☒	***6.*** Other: Click here to enter text.	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to confirm the General Condition 6 &*** **Continuity of Services** ***7 statements included in the paper***			
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

All NHS Foundation Trusts at authorisation are issued with a 'Provider Licence' that sets out conditions by which trusts should operate. A number of conditions also require trusts to make declarations that are prescriptive and are required to be declared within specific timescales. The following declarations are required each year under the specific conditions of the licence:

1 Systems for compliance with licence conditions – in accordance with **General Condition 6** of the NHS provider licence

2 Availability of resources and accompanying statement – in accordance with **Continuity of Services condition 7** of the NHS provider licence. This is required if the Trust has been specifically designated as providing commissioner requested services (CRS) and have been notified by their commissioner. A CRS designation is not simply a standard contract with the commissioners to provide services. CRS are services commissioners consider should continue to be provided locally even if a provider is at risk of failing financially. Providers can be designated as providing CRS because:

   i. There is no alternative provider close enough
   ii. Removing the services would increase health inequalities
   iii. Removing the services would make other related services unviable.

3 Corporate governance statement – in accordance with **condition FT4** of the NHS provider licence

Declaration 1, 2 & 3 are set out in this report for the Board to consider for submission to NHS Improvement.

Regarding declaration 2; the Trust has not been designated by Liverpool CCG as providing "designated commissioner requested services". The Trust does hold CRS relating to those commissioned by NHS England Specialist Commissioned Services and therefore a declaration is required.

Report

General Condition 6

Declaration 1 states
Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended 2018/19; the Licensee took all such precautions as were necessary in order to comply with:

i. the conditions of the licence;

Response: **Confirmed**
Comment: the Trust has taken all precautions as necessary to comply with the conditions of the licence (see attached review of the provider licence). However the Trust was placed in breach of its licence under section 106 of the Health and Social Care Act 2012 by NHS Improvement in April 2016 and was required to enter into an enforcement undertaking to take the necessary steps to address its long term sustainability.

On 23 July 2018, Finance Performance and Business Development Committee undertook a review of the enforcement undertaking and noted that significant progress had been made against each of the provisions. NHSI had indicated that, as the original conditions in the undertaking were largely met, the conditions may be superseded by more relevant undertakings in light of the Trust's forward plan. No new or additional provisions have yet been provided.

ii. any requirements imposed on it under the NHS Acts; and

Response: <u>Confirmed</u>
Comment: There have been no additional requirements imposed on the Trust under the NHS Acts during 2018/19

iii. have had regard to the NHS Constitution in providing health care services for the purposes of the NHS

Response: <u>Confirmed</u>
Comment: The Trust continues to have regard to the provisions contained within the NHS Constitution through the formulation and adoption of trust policies and procedures. The NHS constitution is in line with the Trust's overall vision, aims and values. The Trust governance structure reflects the needs of the NHS constitution and the rights of patients, service users and staff.

Declaration 2 states: The board declares that the Licensee continues to meet the criteria for holding a licence.

The two criteria for holding a Licence are:
1. the Trust must be registered with the Care Quality Commission (CQC); and
2. the directors and governors of the Trust must meet NHS Improvement's fit and proper test.

1. the Trust must be registered with the Care Quality Commission (CQC) – ***Response: Confirmed***

2. For the purposes of the Provider Licence someone who is not a fit and proper person would fall within the following categories:
    - be an undischarged bankrupt;
    - have undischarged arrangements with creditors;
    - be subject to a moratorium period under a debt relief order;
    - have received a prison sentence of three months or longer during the previous five years;
    - be subject to a disqualification order or undertaking

    Comment: During the financial year 2018/19 the Trust remained registered with the CQC and all the directors and governors continue to meet NHS Improvement's fit and proper persons test.
    Response: Confirmed

Overall response:

the Board of Directors on behalf of the Licensee is satisfied, as the case may be that, in the Financial Year most recently ended [2018/19]***, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution***

Continuity of Services Condition 7 – Availability of resources

The Board needs to be satisfied that as:

- Licensee it shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.
- Licensee it shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.
- Licensee, not later than two months from the end of each Financial Year, it shall submit to NHS Improvement a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

Either:
(a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

or:
(b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services".

or:
(c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

In considering the above declarations the Board should be consider whether it has the management, financial, facilities, staff and physical and other assets to meet the needs of CRS. The recently approved operation plan sets out the requirements to meet the delivery of the trust's services in line with the agreed break –even control total with NHSI; recognising that there may still be a requirement for distressed financing should the break-even plan not be achieved.

Last year the Board approved (b) above as this recognises that the Trust has the resources available to meet its CRS requirements however noting that: *the Trust had received an external audit opinion arising from ongoing deficits and an ongoing requirement for distressed financing. However the Trust is deemed to be a going concern and plans to receive ongoing cash support from the Department of Health and Social Care. The Trust has agreed a break-even control total for 2019/20 and expects to have the resources to deliver services for the following 12 months.*

Continuity of Service 7 Recommendation:

It is proposed that the board for the current financial year 2019/20 confirm that:

> ***"after making enquiries the Board of Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available***

to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. "

However in making the above declaration, the Board would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Service.

"The Trust has agreed its control total for 2019/20 and expects to have the resources to deliver services for the following 12 months, however the recently approved operation plan sets out the requirements to meet the delivery of the trust's services in line with the agreed break –even control total with NHSI; recognising that there may still be a requirement for distressed financing should the break-even plan not be achieved."

NEXT STEPS

Once the declarations have been agreed by the board, the declarations will be signed on the Board's behalf by the Chairman and Chief Executive by 31 May 2019 and published on the trust website by 30 June 2019.

RECOMMENDATION

The Board agrees the suggested declarations and responses and requests that the Trust Secretary ensures the declarations are made in accordance with the paper set out above and published on the Trust's website by 30 June 2019.

Liverpool Women's NHS Foundation Trust

Provider Licence

This paper provides assurance that the Trust complies with the terms of its Licence and sets out a broad outline of the licence conditions and any issues for Board to note.

The provider licence is split into six sections, which apply to different types of providers.

1. General conditions (G) – general requirements applying to all licensed providers.
2. Obligations about pricing (F) – obliges providers to record pricing information, check data for accuracy and, where required, charge commissioners in line with tariff. Applies to all licensed providers who provide services covered by national tariff.
3. Obligations around choice and competition (C) – obliges providers to help patients make the right choice of provider, where appropriate, and prohibits anti-competitive behaviour where against patients' interests. This applies to all licensed providers.
4. Obligations to enable integrated care (IC) – enables the provision of integrated services and applies to all licensed providers.
5. Conditions to support continuity of service (CoS) – allows NHS Improvement to assess whether there is a risk to services and to set out how services will be protected if a provider gets into financial difficulty. Applies to providers of commissioner requested services (CRS) only.
6. Governance licence conditions for Foundation Trusts (FT) – provides obligations for Foundation Trusts around appropriate standards of governance. Applies to Foundation Trusts only.

Condition	Provision	Comments
General licence conditions (G)		
1. Provision of information	Obligation to provide NHS Improvement with any information it requires for its licensing functions.	The Trust is currently obliged to provide NHS Improvement with any information it requires and, within reasonable parameters, to publish any information NHS Improvement requires it to. We have systems in place to identify and respond to routine and ad-hoc requests. Formal articulation of this Condition, therefore, does not present any issues for the Trust.
2. Publication of information	Obligation to publish such information as NHS Improvement may require.	
3. Payment of fees to NHS Improvement	Gives NHS Improvement the ability to charge fees and for licence holders to pay them.	There are currently no plans to charge a fee to Licence holders. Trust Board should note that there is, currently, no provision in the budget should such a requirement become payable.

4. Fit and proper persons	Prevents licensees from allowing unfit persons to become or continue as governors or directors.	The Care Quality Commission (CQC) published the fit and proper person requirements to take effect from 1 October 2014. The Trust has included the requirement for members of Trust Board to make an annual declaration against the requirements on an annual basis and has robust arrangements in place for new appointments to the Board (whether non-executive or executive). Governors confirm at appointment that they comply with the requirements.
5. NHS Improvement guidance	Requires licensees to have regard to NHS Improvement guidance.	The Trust responds to guidance issued by NHS Improvement. Each Executive has a responsibility to review Guidance relating to their areas of responsibility and bring any matter to the attention of the other Executive and Board (and to Board Committees)
6. Systems for compliance with licence conditions and related obligations	Requires providers to take reasonable precautions against risk of failure to comply with the licence.	Reviews of the provider licence are undertaken to take into account its conditions within the Board assurance framework and risk processes – failure to comply with the licence is reported to the Board and includes interpretation by NHSI to the Trust's compliance – see enforcement undertaking April 2016. The Trust has a Risk Management Strategy that provides a framework for managing risk across the Trust in line with best practice and Dept. of Health and Social Care Guidelines. The Board Assurance Framework provides assurance regarding the delivery of the Trust's strategic objectives. Real time assessment of the risks and mitigation at all levels within the Trust and reviewed within the Integrated Governance Structure. Independent Assurance is provided as and when required by the Trust's internal and External auditor.
7. Registration with the Care Quality Commission (CQC)	Requires providers to be registered with the CQC and to notify NHS Improvement if their registration is cancelled.	The Trust is registered with the Care Quality Commission (CQC).
8. Patient eligibility and selection criteria	Requires licence holders to set transparent eligibility and selection criteria for patients and apply these in a transparent manner.	The Trusts website sets out the service directories for each service. The Trust has an access policy recently updated that complies with NHSI guidance and best practice. This is made available to the public on the Trust website.
9. Application of section 5 (which relates to continuity of services)	Sets out the conditions under which a service will be designated as a Commissioner Requested Service	Covers all services which the licensee has contracted with a Commissioner to provide as Commission Requested Services (CRS).".

Pricing conditions (P)		
1. Recording of information	Obligation of licensees to record information, particularly about costs.	The Trust responds to guidance and requests from NHS Improvement. Information provided is approved through the relevant and appropriate authorisation processes. The Trust has established financial systems, independently audited which provide service cost information.
2. Provision of information	Obligation to submit the above to NHS Improvement.	
3. Assurance report on submissions to NHS Improvement	Obliges licensees to submit an assurance report confirming that the information provided is accurate.	
4. Compliance with the national tariff	Obliges licensees to charge for NHS health care services in line with national tariff.	All contracts are agreed annually with Commissioners and are in line with the national tariff where applicable. The Board should note that for 2019/20 there is a bock contract in place with the Trust's primary commissioner, Liverpool CCG.
5. Constructive engagement concerning local tariff modifications	Requires licence holders to engage constructively with commissioner and to reach agreement locally before applying to NHS Improvement for a modification.	
Choice and competition (C)		
1. Patient choice	Protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider.	The Trust has in place a service directory setting out the services available. Commissioners monitor the Trust's compliance with the legal right of choice as part of contract monitoring in line with NHS Standard Contract requirements.
2. Competition oversight	Prevents providers from entering into or maintaining agreements that have the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	Trust Board considers that it has no arrangements in place that could be perceived as having the effect of preventing, restricting or distorting competition in the provision of health services. The Trust is aware of the requirements of competition in the health sector and would seek legal and/or specialist advice should Trust Board decide to consider any structural changes, such mergers or joint ventures.
Integrated care condition (IC)		
1. Provision of integrated care	Requires Licensee to act in the interests of people who use healthcare services by facilitating the development and maintenance of integrated services.	The Trust actively works with its partners, through formal and informal mechanisms to foster and enable integrated care and is involved in projects aimed at developing new ways of working and new models of delivery.

Continuity of service (CoS)		
1. Continuing provision of commissioner requested services (CRS)	Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant commissioners.	The Trust does have designated Commissioner requested Services with NHS England. Amendment to Service Specifications would be in accordance with commissioner agreement prior to variation of the contract.
2. Restriction on the disposal of assets	Licensees must keep an up-to-date register of relevant assets used in commissioner requested services (CRS) and to seek NHS Improvement's consent before disposing of these assets IF NHS Improvement has concerns about the licensee continuing as a going concern.	The Trust has an asset register in place. The Trust would require NHSI Consent to the disposal of any relevant assets The Trust would not dispose of an asset that would impact on its ability to provide 'Commissioner Requested Services'
3. NHS Improvement risk rating (standards of corporate governance and financial management)	Licensees are required to adopt and apply systems and standards of corporate governance and management, which would be seen as appropriate for a provider of NHS services and enable the Trust to continue as a going concern.	The Trust has robust and comprehensive corporate and financial governance arrangements in place with assurance received from an internal audit in 2018/19. The Trust complies where-ever possible with Corporate Governance good practice including the Code of Governance and follows guidance issued by NHSI. The Trust maintains good financial governance processes such that it can continue as a going concern, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future, with continued distressed finance support. The Board receives assurance on the good financial governance from MIAA through their internal audit reports.
4. Undertaking from the ultimate controller	Requires licensees to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause the licensee to breach its licensing conditions.	Does not apply to the Trust.
5. Risk pool levy	Obliges licensees to contribute to the funding of the 'risk pool' (insurance mechanism to pay for vital services if a provider fails).	This condition has not been enacted by NHS Improvement. If it was this would create a significant cost pressure on the Trust.

6. Co-operation in the event of financial stress	Applies when NHS Improvement has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern and in such circumstances obliges the licensee to co-operate with NHS Improvement.	The Trust is aware it needs to co-operate with NHS Improvement in such circumstances.
7. Availability of resources	Requires licenses to act in a way that secures resources to operate commissioner requested services (CRS).	The Trust has sound and robust processes and systems in place to ensure it has the resources necessary to deliver its services. Trust undertakes robust contract discussions and undertakes early identification of CIP schemes supported by PID, QIA and EIA. The Trust has agreed its control total for 2019/20 and expects to have the resources to deliver services for the following 12 months, however the recently approved operation plan sets out the requirements to meet the delivery of the trust's services in line with the agreed break –even control total with NHSI; recognising that there may still be a requirement for distressed financing should the break-even plan not be achieved.
Foundation Trust conditions (FT)		
1. Information to update the register of NHS foundation trusts	Obliges foundation trusts to provide information to NHS Improvement.	See G1. The Trust is currently obliged to provide NHS Improvement with any information it requires, including information to update its entry on the register of NHS foundation trusts.
2. Payment to NHS Improvement in respect of registration and related costs	The Trust would be required to pay any fees set by NHS Improvement.	NHS Improvement has undertaken not to levy any registration fees on foundation trusts without further consultation.
3. Provision of information to advisory panel	NHS Improvement has established an independent advisory panel to consider questions brought by governors. Foundation trusts are obliged to provide information requested by the panel.	The independent advisory panel was established in April 2013 and the Trust provides a briefing on the Panel for the Governors. The Trust's governors understand the role and remit of the Panel and the seriousness of any reference to it, representing a breakdown of the existing communication channels between the Trust Board and the Council of Governors.
4. NHS Foundation Trust governance arrangements	Gives NHS Improvement continued oversight of the governance of foundation trusts.	The Trust has sound corporate governance processes in place and reviews of these arrangements are a core part of the internal audit annual work program.

		Agenda Item	**2019/081**
MEETING	**Trust Board Meeting**		
PAPER/REPORT TITLE:	**Proposed Risk Appetite Statement 2019/20**		
DATE OF MEETING:	**2nd May 2019**		
ACTION REQUIRED	**For Approval**		
EXECUTIVE DIRECTOR:	Caron Lappin, Director of Nursing and Midwifery		
AUTHOR(S):	Christopher Lube, Head of Governance and Quality		
STRATEGIC OBJECTIVES:	***Which Objective(s)?***		
	To develop a well led, capable, motivated and entrepreneurial *workforce*	**X**	
	To be ambitious and *efficient* and make the best use of available resource	**X**	
	To deliver *safe* services	**X**	
	To participate in high quality research and to deliver the most *effective* Outcomes	**X**	
	To deliver the best possible *experience* for patients and staff	**X**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***		
	Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust	**X**	
	The Trust is not financially sustainable beyond the current financial year	**X**	
	Failure to deliver the annual financial plan	**X**	
	Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision	**X**	
	Ineffective understanding and learning following significant events	**X**	
	Inability to achieve and maintain regulatory compliance, performance and assurance	**X**	
	Inability to deliver the best clinical outcomes for patients	**X**	
	Poorly delivered positive experience for those engaging with our services	**X**	
CQC DOMAIN	***Which Domain?***		
	SAFE- *People are protected from abuse and harm*	☐	
	EFFECTIVE - *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.*	☐	
	CARING - *the service(s) involves and treats people with compassion, kindness, dignity and respect.*	☐	
	RESPONSIVE – *the services meet people's needs.*	☐	
	WELL-LED - *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.*	☐	
	ALL DOMAINS	**X**	

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution	**X**	**4.** NHS Constitution	☐
	2. Operational Plan	**X**	**5.** Equality and Diversity	**X**
	3. NHS Compliance	**X**	***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	2 . This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is requested to receive the recommendations of its sub-committees regarding risk appetite and risk tolerance levels for 2019-20 and approve the Risk Appetite Statements for 2019-20.			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Quality Committee Putting People First Committee Finance, Performance and Business Development Committee	
	Date of meeting		March/April 2019	

1. Executive Summary

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

What is Risk Appetite?

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

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

What is the Process?

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

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

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

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

The Board is requested to receive the recommendations of its sub-committees regarding risk appetite and risk tolerance levels for 2019-20 and approve the Risk Appetite Statement for 2019-20.

2. Report

Risk Appetite Levels

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

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

Proposal for 2019/20 Risk Appetite Statement

Following review and discussion at sub –committees of the board the following Risk Appetite Statement for 2019/20 is proposed for review by the Trust Board.

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

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

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

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

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

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

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

investigate our incidents and we will ensure that we continue to learn lessons to improve the safety and quality of our services.

To participate in high quality research and to deliver the most **effective** outcomes is a **High risk appetite**
Liverpool Women's NHS Foundation Trust supports **High** risk against this objective. A level of service redesign to improve patient outcomes that requires innovation, creativity, and clinical research are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.

This is a proposed change from 2018/19 when the risk appetite was agreed as Moderate. Following discussion at Quality Committee it is recommended that the risk appetite be increased to **High,** due to the Trust participating in high quality research and as a consequence the Trust would be open to consider all potential delivery options.

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

3. Conclusion

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

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

4. Recommendations

The Board of Directors is asked to:

a) Receive the recommendations of its sub-committees regarding risk appetite and risk tolerance levels for 2019/20
b) Approve the Risk Appetite Statements for 2019/20.

5. Appendix

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

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

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

Board Assurance Framework

To be added