**Meeting of the Board of Directors**
**HELD IN PUBLIC**
**Thursday 4 July 2019 at 0930hrs**
**Liverpool Women's Hospital**
**Board Room**

| Item no.<br><br>2019/ | Title of item | Objectives/desired outcome | Process | Item presenter | Time | CQC Domain |
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| | Thank you | To provide personal and Team thank you – above and beyond | | | 0930 (10mins) | Caring |
| 096 | Apologies for absence<br>Declarations of interest | Receive apologies | Verbal | Chair | | - |
| 097 | Meeting guidance notes | To receive the meeting attendees' guidance notes | Written | Chair | | Well Led |
| 098 | Patient Story | To receive a patients story | Presentation | Gynaecology | 0940 (20mins) | Safe, Experience, Well led |
| 099 | Minutes of the previous meeting held on 2 May 2019 & 16 May 2019 | Confirm as an accurate record the minutes of the previous meetings | Written | Chair | 1000 (5mins) | Well Led |
| 100 | Action Log and matters arising | Provide an update in respect of on-going and outstanding items to ensure progress | Written | Chair | | Well Led |
| 101 | Chair's announcements | Announce items of significance not found elsewhere on the agenda | Verbal | Chair | 1005 (10mins) | Well Led |
| 102 | Chief Executive Report | Report key developments and announce items of significance not found elsewhere on the agenda | Written | Chief Executive | | Well Led |
| BOARD COMMITTEE ASSURANCE | | | | | | |

| Item no.<br><br>2019/ | Title of item | Objectives/desired outcome | Process | Item presenter | Time | CQC Domain |
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| 103 | Chair's Report from Audit Committee | For assurance, any escalated risks and matters for approval | Written | Committee Chair | 1015 (20mins) | Well Led |
| 104 | Chair's Report from Finance, Performance and Business Development Committee | For assurance, any escalated risks and matters for approval | Written | Committee Chair | | Well Led |
| 105 | Chair's Report from Quality Committee | For assurance, any escalated risks and matters for approval | Written | Committee Chair | | Safe<br>Well Led |
| 106 | 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 | | | | | | |
| 107 | Director of Infection, Prevention and Control Annual Report 2018/19 | For assurance | Written/ Presentation | Tim Neal, DIPC | 1035 (20mins) | Safe, Well Led, caring |
| 108 | National Maternity Review – Better Births | For assurance | Written | Clare Fitzpatrick, Head of Midwifery | 1055 (20mins) | Safe Well Led Caring |
| TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES | | | | | | |
| 109 | i) Safer Nurse/Midwife Staffing Monthly Report period M2 2019/20<br><br>ii) Safe Staffing – Bi Annual Report | For assurance and to note any escalated risks | Written | Deputy Director of Nursing and Midwifery | 1115 (10mins) | Well Led, caring, Safe |
| 110 | Operational Performance Report period M2, 2019/20 | For assurance –To note the latest performance measures | Written | Sarah Sherrington, Interim Service Improvement and Business Manager | 1125 (10mins) | Well Led |
| 111 | Finance Report period M2, 2019/20 | For assurance - To note the current status of the Trusts financial position | Written | Director of Finance | 1135 (10mins) | Well Led |
| TRUST STRATEGY | | | | | | |

| Item no.<br><br>2019/ | Title of item | Objectives/desired outcome | Process | Item presenter | Time | CQC Domain |
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| 112 | Future Generations – Clinical Sustainability of Services | For noting. | Verbal | Chief Executive | 1145 (10mins) | Safe Well Led |
| BOARD GOVERNANCE | | | | | | |
| 113 | Board Assurance Framework 2019/20 | For assurance and approval | Written | Trust Secretary | 1255 (10mins) | Well Led |
| 114 | Review of risk impacts of items discussed | Identify any new risk impacts | Verbal | Chair | 1205 (10mins) | Well Led |
| HOUSEKEEPING | | | | | | |
| 115 | Any other business & Review of meeting | Consider any urgent items of other business | Verbal | Chair | 1215 Meeting ends | Well Led |

Date of next meeting

Board in Public: 5 September 2019

## Meeting to end at 1215

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| 1215-1230 | Questions raised by members of the public observing the meeting on matters raised at the meeting. | To respond to members of the public on matters of clarification and understanding. | Verbal | Chair |

# Meeting attendees' guidance, April 2018

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

## Before the meeting

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

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

## At the meeting

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

## Attendance

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

## After the meeting

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

## Standards & Obligations

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

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

Page 129 Handbook to the NHS Constitution 26th March 2013

Board Agenda item 2019/099(i)

## Board of Directors

Minutes of the meeting of the Board of Directors
held in public on 2 May 2019
at Liverpool Women's NHS Foundation Trust, Crown Street Liverpool.

*PRESENT*

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| Mr Robert Clarke | Chair |
| Mrs Kathryn Thomson | Chief Executive |
| Mr Phil Huggon | Non-Executive Director |
| Dr Devender Roberts | Acting Medical Director |
| Prof Louise Kenny | Non-Executive Director |
| 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*

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| Mr Colin Reid | Trust Secretary |

*APOLOGIES*:

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| Mrs Michelle Turner | Director of Workforce & Marketing & Deputy Chief Executive |
| Mr Tony Okotie | Non-Executive Director/SID |
| Ms Jo Moore | Non-Executive Director & Vice Chair |
| Mrs Tracy Ellery | Non-Executive Director |

| 2019 | |
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| | **Thank You**<br>**Stephen Molloy - Librarian:** The Acting Medical Director thanked on behalf of the Board, Stephen Molloy for his diligence in the provision of the library services at the Trust. He is a well-known person amongst the clinical staff and is always on hand to support all staff always going above and beyond.<br><br>**Jackie Matthews – League of Friends:** The Director of Nursing and Midwifery introduced Jackie Matthews. Jackie is a volunteer with the League of friends who not only, as a team support the Trust with their continued fundraising activity but also Jackie has been fully engaged in the Patient Experience week at the Trust and the Nursing, Midwifery and operating department practitioner's day. The Director of Nursing thanked Jackie and the League of Friends for the continued support and in the provision of cakes to the nursing, midwifery ODP teams which was well received. |
| 063 | **Apologies** – as above.<br>**Declaration of Interests** – None<br>**Welcome:** The Chair opened the meeting and welcomed everyone present. |
| 064 | **Meeting guidance notes**<br>The Board received the meeting attendees' guidance notes. |

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| 065 | **Staff Story Presentation – Gynaecology**<br>The staff/patient Story was provided by Gill Walker, Matron, Division of Gynaecology.<br><br>Gill Walker explained that the story went to the heart of providing the best quality of care to patients in need and explained that the patient, Miss Smith (alias name used) was admitted to the hospital on request from the police. She was vulnerable and required a safe haven being that she was far away from home. Gill Walker advised that she was not able to give the reasons for the patient being admitted to the hospital, however when she arrived she had no belongings and was not necessarily in need of physical care, however what she did need was compassionate holistic care, which was delivered by a number of key individuals. Gill Walker reported the following:<br><br>*Miss Smith attended the Gynaecology Emergency Department (GED), she was in her early twenties and had a learning disability; she was also dehydrated and arrived in a vulnerable state. On admission to the ward a comprehensive review of Miss Smith was undertaken of both her physical and safeguarding needs. This was recorded in the nursing notes and on the Meditech Bulletin Board which was available to Trust staff including Safeguarding, with a referral to the safeguarding team was also made.*<br><br>*Miss Smith was comfortable overnight and did manage to sleep. The following morning, she was reviewed by the ward Matron, who noted that Miss Smith did not have any belongings or clothing with her. Miss Smith's grandmother was not able to come from Wales as she could not afford the travelling expenses.*<br><br>*The ward staff, Matron and Head of Nursing did not want Miss Smith to be discharged from the Trust in her hospital gown and in order to help Miss Smith and provide some dignity, Matron and Head of Nursing scoured the Trust for any items of lost property / clothing which could be provided to Miss Smith. Eventually following a suggestion from one of the Midwives, Father Peter the local Priest was contacted. Father Peter holds a small charitable fund for supporting asylum seekers to help with clothing etc. Due to confidentiality restraints Father Peter was given a short summary of Miss Smith and he immediately made arrangements to support Miss Smith in the provision of a small bundle of clothing and toiletries that arrived on the Gynaecology ward a short time after the request was made. Miss Smith was discharged from the Trust's care later that day and was able to return home to Wales.*<br><br>Gill Walker advised that the story demonstrated exemplary compassionate care delivered to Miss Smith to support her holistic needs by the nursing team in the GED and Gynaecology inpatient ward and showed that that early intervention and proactive inclusion of relevant teams helped ion the provision of quality of care to support Miss Smith at such a difficult time for her.<br><br>The Chief Executive thanked the whole team in the provision of the care they provided to the patient and noted the need to consider what the Trust could provide to patients using the services of the Trust in terms of the basics such as toiletries when being discharged. She felt that it was important that the Trust was able to link to those 'other' support and social services to give the best possible outcome to patients whilst using the Trust's services and at discharge.<br><br>The Chair on behalf of the Board thanked Gill Walker for her presentation and welcomed the initiatives that he hoped would come out of the patient story. |
| 066 | **Minutes of previous meeting**<br>The minutes of the board meeting held on 4 April 2019 were approved. |

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| 067 | **Matters arising and action log.**<br>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.<br><br>With regards to the proposed amendment to action 2019/045, the Board agreed with the proposal from the Director of Nursing and Midwifery that 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.<br><br>With reference to page 5 of the minutes relating to the partial assurance the Quality Committee had received in relation to the implementation of LocSSIPs (Local Safety Standards for Invasive Procedures), the Board noted that the Committee would receive an updated report at its June meeting to provide the required full assurance. |
| 068 | **Chair's Announcements**<br>The Chair reported on the following matters:<br><br>**Council of Governors & Governor elections**: The Chair advised on the Council of Governors meeting held the previous evening and felt that the relationship between the Council and the Board remained strong. He noted that the introduction of the sub groups of the Council continued to be supported by Governors and was an effective vehicle to discuss issues being addressed by the Board whilst providing assurances the Council needed on the financial and operational performance of the trust and quality of care afforded to patients. Referring to the forthcoming annual elections the Trust Secretary advised that there would be three public and three staff constituencies where elections would be required to take place. He advised that the Trust would continue to use the Electoral Reform Services as the independent returning officer for the elections which would take place commencing July 2019.<br><br>**Chairs meetings**: The Chair advised on his meeting with the new Chair of Southport and Ormskirk Hospitals NHS Foundation Trust at which he discussed the local health economy and the role of the Cheshire and Merseyside Health and Care Partnership.<br><br>**Dedicated to Excellence Awards:** The Chair thanked all involved in the organisation of the dedicated to excellence awards that took place on 18 April 2019, particularly the Communications Team in making it a success. He referred to the Chief Executive Report that provided additional details on the winners of the awards. The Chief Executive echoed the Chairs Comments and felt that the evening had gone exceptionally well with all staff enjoying themselves. She also liked to thank the communications team for all their hard working in making the event such an enjoyable one.<br><br>**Appointment to the Role of Director of Operations:** The Chair reported on the recent recruitment of Gary Price to the post of Director of Operations. He reported that Gary Price would join the Trust in July from Wirral University Teaching Hospital NHS Foundation Trust, at which he is Director of Operations for their Women and Children's Division.<br><br>The Board noted the Chair's verbal update. |
| 069 | **Chief Executive's report**<br>The Chief Executive and Executive team commented on the following:<br><br>**Patient Experience Week:** The Director of Nursing and Midwifery reported on the success of the Patient Experience Week. She advised that the event was embraced by all staff and governors and helped raise the profile in the improvement of care to patients. The Director of Nursing advised on the success of the activities, which included 'Ask the Matron' that provided the opportunity for the |

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| | public to ask questions of Matrons on social media. She advised that this activity would continue going forward, subject to continued interest from the public.<br><br>Generation IT: Referring to the #Generation IT event, the Chief Executive felt the event provided a real look into the future of how patient care and services would be delivered.<br><br>Making Every Contact Count (MECC): The Chief Executive highlighted the initiative 'Making Every Contact Count' noting that there would be more on this initiative later in the year which enables staff to be proactive in facilitating greater awareness to patients and service users of health and wellbeing initiatives.<br><br>Operational Plan 2019/20: The Chief Executive reported that the Trust had submitted to NHS Improvement its approved financial and operational plan 2019/20. She reported that the Trust had been able to develop a financial plan for 2019/20 which delivers the breakeven control total set by NHS Improvement (NHSI). The Director of Finance advised that this was a challenging plan to achieve and contained several risks to delivery. She went on to explain that the plan reflects ongoing investment in the clinical case for change and keeping services safe on site whilst the Trust continued to push forward the preferred option of co-location with the local adult acute provider.<br><br>The Chair thanked the Chief Executive for presenting her Report, which was noted. |
| 070 | Chair's Report from Finance, Performance and Business Development Committee (FPBD)<br>Due to Jo Moore being unavailable for the meeting the Chair asked Phil Huggon to present the Chairs Report from the FPBD meeting held on 23 April 2019.<br><br>Referring to operational performance for RTT and Cancer, Phil Huggon advised that the Committee had raised concern regarding the lack of assurance the Committee was receiving in relation to the trajectory being reported for delivery of RTT and Cancer targets which had continued to change over a short period of time. He advised that further discussion on this would be picked up under the agenda item 2019/076.<br><br>Referring to the Finance Performance Review Month 12 2018/19, Phil Huggon was please to report that the Trust had exceeded the agreed control total by £0.6m. He advised that the Committee had further noted that a notification had been received from NHSI, indicating that the Trust would receive £6.8m PSF rather than £3.6m, resulting in a year end outturn position of a £2.1m surplus. Ian Knight sought an understanding on whether the Trust would be repaying its current loans with the Department of Health. The Director of Finance confirm that would be the case and would report further under her Finance Report later in the meeting. Phil Huggon congratulated the Director of finance and her team on a well-managed outturn. Referring to CIP he reported that the Committee had noted and were sighted on the 2019/20 delivery of CIP, reference that £2m of CIP was made up of three schemes.<br><br>Referring to the two matters that required action by the Board, Phil Huggon asked the Board to receive the Annual Report 2018/19 and agree to the changes to the BAF, which was reported in the Chairs report and also under agenda item 2019/082.<br><br>The Chair thanked Phil Huggon for his report. The Board received the assurances provided by the Committee and received the FPBD Annual Report 2018/19. |
| 071 | Chair's Report from Quality Committee (QC)<br>Susan Milner presented the Chair Report from the Quality Committee meetings held on 23 April 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 CQC Action Plan, Susan Milner reported that the Committee received assurance on the progress being made and was nearly complete with only a few actions outstanding.

Susan Milner referred to the Quality Performance review and reported that the Committee had noted the concerns expressed at FPBD regarding the trajectory for delivering RTT and cancer targets.

With regards to the Serious Incidents Report, Susan Milner reported that the Committee had discussed whether there was a system in place that would flag when similar SIs and Never Events occurred; noting that an action had been placed on the Head of Governance to look at how this could be flagged in future reports. The Chief Executive questioned whether the action was to include never events as she felt they were, hopefully, very few in number and that this information would already be collated. The Chair asked that clarification was sought on the scoping of the action for discussion at the Quality Committee.

Susan Milner reported that the Committee had received the draft Quality Report 2018/19, the final version of which would be presented to the Audit Committee and Board on 16 May 2019. She advised that the Committee had noted that the Report was due to be presented to local stakeholders before being presented to the Audit Committee and Board for comment. The Committee had noted that the format of the Report had not changed significantly from last year and comments had been asked from Committee members prior to submission to the Audit Committee and Board.

Referring to the Committee's Annual Report 2018/19, Susan Milner reported that the Committee had met nine times during the year and had dealt with all matters under its areas of responsibility, as referenced in the Report.

The Chair thanked Susan Milner for her report. The Board received the assurances provided by the Committee and received the Quality Committee's Annual Report 2018/19.

072 **Chair's Report from Putting People First Committee**

Due to the unavailability of Tony Okotie, the Chair updated the Board on the work of the Putting People First Committee from the meeting held on 23 April 2019.

The Chair commented that the meeting had received a large number of annual reports reflecting that it was the first meeting following the financial year end. He went on to explain that the Committee had received the required assurance from each Report presented.

Referring to the Board assurance framework, the Chair advised on the recommendations from the Committee which would be discussed later in the meeting. The Chair noted the assurance provided on actions being taken in Maternity to address its workforce risks and the plans in place to mitigate them. He advised that this included the work linked to the NHSI Sickness Improvement project and further work to be linked to the development of its talent mapping and workforce plans. The Chair referred to the work of the Committee regarding sickness absenteeism and the deep dive requested on the themes and reasons for absenteeism.

The Board received the assurances provided by the Putting People First Committee and:

1. noted the changes to the articulation of the workforce related BAF risks that would be discussed later in the meeting;
2. noted the Risk Appetite statement 2019/20 which would be discussed later in the meeting;
3. noted the progress and delivery of the workforce related corporate objectives for 2018/19 and to approve the new workforce related corporate objectives for 2019/20, to be discussed later in the meeting
4. received the Committee's Annual Report 2018/19 as presented; and

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| | 5. approved the Committee's Terms of Reference as presented. |
| 073 | **Liverpool Health Partners- Trust's participation 'Starting Well'**<br>The Chief Executive introduced the presentation and advised that she had asked for the presentation as she felt it would be helpful for the Board to get an understanding of the work that the Trust would be engaged in as part of the Liverpool Health Partners Strategy agreed by the Board last year. She went on to advise that the Trust would be involved primarily in the 'Starting Well' element strategy and introduced Colin Morgan, Consultant Neonatologist who would be leading on this on behalf of the Trust.<br><br>Colin Morgan introduced himself and LHP project manager for Starting Well, Carrie Hunt and presented the Starting Well LHP Programme of work which set out the case for change, explaining where the City was in relation to the rest of England and regionally in relation to infant mortality, life expectancy and inner-city depravation.<br><br>Colin Morgan explained the Starting well principles and in particular the patient and public involvement and engagement that was required together with the objectives that had been set for 2019/20 which included: building a proactive and collaborative 'Starting Well' community to identify and define our local priorities; through priority setting, develop an evidence-informed roadmap for tackling health needs and improving health outcomes; and from these two objectives, design a Starting Well programme that is fully endorsed by all key stakeholders.<br><br>Carrie Hunt explained the plan for the year which included building the community through: developing collaboration through shared priorities and supporting existing collaboration and scope further opportunities; working with partners to explore ways to promote and embed research engagement - to showcase and inspire; and exploring effective mechanisms for research capacity building for all staff and showed a road map that set out the starting well framework.<br><br>Louise Kenny commented on the context that the City found itself, she explained that the city was unique in not having a strategy that delivered health research. In particular Louise Kenny recognised the depravation in the City and the infant mortality which was 30% higher than other large cities and felt that there was an imperative that the City had its own Biomedical Research Centre (BRC) to support translational research to transform scientific breakthroughs into life-saving treatments for patients otherwise the City would continue to fail its patients.<br><br>The Chief Executive felt that it would be helpful for the Trust to engage fully in the starting well programme and felt that the Board needed to be focused on how the Trust inputs along the trainline referring to the work/initiatives the Trust was doing that would impact on it such as: patient stories and actions arising from them from a social perspective; making every contact count; adult mortality; still births; perinatal mortality; quality metrics etc.. The Chief Executive felt that it was important that the Board challenge what it was doing along the Trainline. It was also felt that there needed to be a commitment across the city between NHS providers and Universities to commit to the formation of a Liverpool BRC. The Chief Executive asked that the Acting Medical Director and Director of Nursing and Midwifery map out where the Trust was able to input along the Trainline and asked that this was taken through the Quality Committee.<br><br>*Action 2019/073: The Acting Medical Director and Director of Nursing and Midwifery to map out where the Trust was able to input along the 'Starting Well' Trainline for review by the Quality Committee.*<br><br>The Board discussed further the Starting Well framework and the need for the Trust to engage fully in the programme. There was recognition that research was not just a medical necessity it was everyone's business. |

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| | The Chair thanked Colin Morgan and Carrie Hunt on behalf of the Board for their presentation and summed up the view of the Board that it was important that the Trust was engaged fully in the Starting Well Programme and supported the need for better linkages across providers and universities in the City. He asked that the Board is kept apprised on the programme. |
| 074 | Guardian of Safe working – Annual report 2018/19<br>The Acting Medical Director presented the Guardian for Safe Working Annual Report 2018/19 noting that over the year a quarterly report had been presented to the Putting People First Committee. The Chair noting the position asked for any questions on the Report.<br><br>There being no questions the Board received the Guardian of Safe working – Annual report 2018/19. |
| 075 | (i) Safer Nurse/Midwife Staffing Monthly Report Period 12 2018/19<br>The Director of Nursing and Midwifery presented the safer staffing report for month 12 which was taken as read. The Chair asked whether the Trust was keeping sufficiently ahead of recruitment, in response the Director of Nursing and Midwifery reported that the Trust actively recruits staff ahead of requirement. Responding to a question on the national shortages of general nurses, the Director of Nursing and Midwifery reported that the Trust was not having difficulty in recruiting nursing staff, however she was mindful that this may not continue in future years and was looking at how the Trust continues to make itself an attractive place for nurses to seek employment.<br><br>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.<br><br>(ii) Safe Staffing – Headroom & Birth Rate plus<br>The Director of Nursing and Midwifery presented her paper on Headroom and birth rate plus. She explained the meaning of headroom advising that it was a 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 and explained that this typically does not cover maternity leave. The Director of Nursing and Midwifery advised that 18.9% allowance was used throughout the Trust in all specialities in 2018/19 and reported that this was benchmarked as low against other trusts. The Director of Nursing and Midwifery advised concern had been expressed by managers who had identified that the current allowance for headroom did not allow enough time for clinical staff to complete all required training.<br><br>The Director of Nursing and Midwifery reported that as part of the 2019/20 budget setting and operational planning process the allowance was re-assessed across all areas and the revised percentage allowances used in setting budgets for 2019/20; the budget for 2019/20 having been agreed by the Board. The Director of Nursing and Midwifery reported that the recalculated allowance for headroom for 2019/20 for maternity was 21.4% and for the other specialities 21.0% and took into consideration an assessment of actual leave entitlement and rebased to match the Trust's sickness target of 4.5%. Training was also re-assessed with the relevant Head of Nursing/Midwifery agreeing the mandatory training requirement for each area. The Director of Nursing and Midwifery advised that this averaged 5 days per year for Maternity and 4 days per year for all areas as set out in the paper. She advised that this had also been discussed at length and more widely in each division and in cross divisional planning meetings and reviewed and agreed by herself and/or the Deputy Director of Nursing and Midwifery as appropriate. The Director of Nursing and Midwifery advised that maternity leave would continue to remain a pressure on the budget and was not included in the headroom allowance. |

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| | The Chair noting that the Board had previously approved the budget sought assurance that the use of resources to support the change in allowance would have a positive impact and see improvements in completion of mandatory training over the year. The Chief Executive noted the comment and advised that there were a number of initiatives that the Trust was involved in that impacted on resource including CNST, every contact count, staff survey and compliance with mandatory training. She felt that it was important for the Board to support the increase in allowance however felt that it also important that it sees positive outcomes and asked the Director of Nursing and Midwifery and Director of Workforce and Marketing to consider what people and quality measures could provide that assurance. The Chief Executive also felt that with the introduction of the new divisional structure there would be greater challenge from both within the division and at divisional monthly reviews. Ian Knight felt that this was a good news story and should be communicated as such.<br><br>The Director of Nursing and Midwifery, referring to Birth Rate Plus tool, explained that the tool provides the basis for the calculation of the required number of midwives, support staff and non-direct care giving staff, such as managers, based on the type of activity in each midwifery setting. The Director of Nursing and Midwifery reported that the calculation, given the expected rate of activity, gave high level assurance that there was a safe level of staffing within each midwifery setting.<br><br>The Chair thanked the Director of Nursing and Midwifery for her report and sought the Board approval of the recommendations in the paper.<br><br>The Board approved the revised headroom percentage allowance and investment in Birth Rate Plus outlined in the paper. |
| 076 | Performance Report Period 12 2018/19<br>The interim Director of Operations presented the Performance Report for period 12 2018/19 and explained that for RTT and Cancer the validated data for March 2019 was not available and her report was based on the validated data for February 2019.<br><br>The Interim Director of Operations provided a short summation of the Trust's performance in delivery of the Cancer and RTT and explained that for 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. She advised that the reduction in performance was anticipated to be short term only following the consultants return to work. Referring to RTT the Interim Director of Operations reported that February also experienced significant challenges for gynaecology services due to high levels of consultant sickness. She advised that 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. The Interim Director of Operations advised that with the capacity issues persisting in Uro-Gynaecology, two consultants were successfully recruited in March 2019 to address this shortfall both of which were due to commence employment with the Trust in May 2019. The Board discussed the isolated site issues being faced by the Trust in the recruitment of good quality Gynaecology consultants and noted the success in making these appointments. Louise Kenny felt that greater partnering with the University of Liverpool may help support the recruitment processes for consultants with the possibility of an offer of a short-term academic position. She felt it was important that the Trust think in broader terms way of attracting candidates.<br><br>The Chief Executive supported the comments from Louise Kenny and referred to the performance report. She felt that there were still some risks associated with getting the Trust back on trajectory noting that even with the recruitment of additional consultants there would always be a lead time that included at what rate they could work. The Chair noted the comments made at the Finance Performance and Business Development Committee regarding the lack of assurance the Committee was receiving in relation to the trajectory being reported for delivery of RTT and Cancer targets which |

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| | had continued to changeover a short period of time and commented that there was a real need for the Board and committees to receive assurance on what the trajectory was in delivery of cancer and RTT and requested that more analysis was needed to provide that assurance. The Chief Executive noted the comments and referred to the short-term issues that could not have been foreseen regarding sickness absenteeism over the past few months that had led to the recovery stalling. She agreed however that assurance would be provided going forward.<br><br>The Board noted the Performance Report for period 12, 2018/19 noting the risk of non-delivery of RTT and Cancer and lack of assurance regarding the trajectory to recover the Trust's position. The Chair thanked the interim Director of Operations for her report. |
| 077 | Financial Report & Dashboard Period 12 2018/19<br>The Director of Finance presented the Finance Report and financial dashboard for month 12, 2018/19 and reported that at month 12 the Trust was reporting a full surplus of £2.2m against a deficit budget of £1.6m, giving a year to date favourable variance of £3.8m. She advised that this was due to receipt of the additional Provider Sustainability Funding at year end. The Director of Finance advised that as a consequence she was looking at reducing the amount of debt held on the Trust's books and would be looking to re-pay the current distressed financing loans with the Department of Health and Social Care.<br><br>Referring to activity the Director of Finance advised that the Trust benefitted from the acting as one contract with Liverpool CCG and was encouraged that the 2019/20 contract for the most part was also a block arrangement. She went on to report that there would be a requirement for the Trust to produce a five year plan from 2020/21 and that her team was actively opening discussion with the commissioners to address how the contracts would be formed.<br><br>The Chair thanked the Director of Finance for presenting the Financial Report & Dashboard Period 12, 2018/19 which was received. |
| 049 | Future Generations – Clinical Sustainability of Services<br>The Chief Executive reported on the arrangements being put in place for the clinical summit due to be held on 11 June 2019 as reported last month. She advised that the Board and clinicians had continued to actively review the clinical challenges faced by the trust since 2014. The Chief Executive explained that following the summit the Board would have to consider the findings and what impact the findings would have on the services provided by the Trust. 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.<br><br>The Chief Executive advised of her meeting with Bill McCarthy, North West Regional Director NHS Improvement/England and the meeting between the Medical Director and a number of Executive Directors and David Levy, NHS North West Regional Medical Director, who also received a tour of the hospital. |
| 079 | Corporate Objectives 2018/19 outturn and Corporate Objectives 2019/20<br>The Chair asked that the paper be taken as read given that each of the Board Committees had reviewed the corporate Objectives Outturn 2018/19 and the corporate objectives for 2019/20 and sought comments. There being no additional comments the Board approved the performance for the year against the Corporate Objectives 2018/19; and the Corporate Objectives 2019/20. |
| 080 | NHS Improvement compliance: Provider Licence General Condition 6 and Continuity of Services 7<br>The Trust Secretary presented the paper setting out the Trust's compliance with General Condition 6 and continuity of services 7 contained in the provider licence. The Board approved compliance with general condition 6 and continuity of services 7 as set out in the paper. |

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| 081 | Risk Appetite Statement 2019/20<br>The Board approved the risk appetite statement noting the outcome of discussions at the Board committees on the statement that had been reported through the Chairs report for each committee. |
| 082 | Board Assurance Framework<br>The Trust Secretary presented the Board Assurance Framework 2018/19 and the Board Assurance Framework 2019/20. He explained the process that had been undertaken regarding the year-end review by the sub-committees which had been completed for the close out of the 2018/19 financial year and the commencement of the 2019/20 financial year.<br><br>The Board discussed the content of the report noting in particular the closure of those risks not perceived as significant risks to achieving the strategic objectives of the Trust and the amendments to risks already contained in the BAF.<br><br>The Board approved the BAF closure for 2018/19 and the resetting for 2019/20, noting that each committee, at its next meeting, would review those risks removed or proposed to be removed from the BAF to satisfy itself of the appropriateness of the removal. |
| 083 | Review of risk impacts of items discussed<br>The Board noted the following additional risks identified during the meeting:<br>• Trajectory for delivery of RTT and Cancer national targets<br>• Delivery of CIP 2019/20<br>• Learnings from Serious Incidents and historical review<br>• Wider Local health economy and requirements for Liverpool to have its own BRC. |
| 084 | Any other business & Review of meeting<br>There was no other business.<br><br>The Board noted the honest, transparent, frank and challenging discussion on items presented.<br><br>Date of next meeting<br>The Chair reported that the next meeting of the Board in public would be 4 July 2019. |

2019/099(ii)

# Board of Directors

Minutes of the meeting of the Board of Directors
held public on 16 May 2019 at 1130hrs
in the Boardroom, Liverpool Women's Hospital, Crown Street

PRESENT

| | |
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| Mr Robert Clarke | Chair |
| Mrs Kathryn Thomson | Chief Executive |
| Mrs Jenny Hannon | Director of Finance |
| Dr Devender Roberts | Acting Medical Director |
| Mrs Caron Lappin | Director of Nursing & Midwifery |
| Ms Loraine Turner | Interim Director of Operations |
| Ms Jo Moore | Non-Executive Director /Vice Chair |
| Mr Ian Knight | Non-Executive Director & Chair of Audit Committee |
| Mr Tony Okotie | Non-Executive Director/SID |
| Dr Susan Milner | Non-Executive Director |
| Mrs Tracy Ellery | Non-Executive Director |

IN ATTENDANCE

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| Mr Colin Reid | Trust Secretary |

APOLOGIES

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| Mrs Michelle Turner | Director of Workforce & Marketing |
| Prof Louise Kenny | Non-Executive Director |
| Mr Phil Huggon | Non-Executive Director |

095 **Apologies** – As above

The Chair opened the meeting and reported that the meeting had been called to approve the Annual Report and Accounts 2018/19. He advised that just prior to the meeting the Audit Committee had met with Board members in attendance, together with the internal and external auditor and key members of staff who had been involved the production of the Annual Reports and Accounts.

096 **Meeting guidance notes**
The Board noted the meeting guidance notes.

097 **Declaration of Interests**
There were no declarations of interest.

098 **Annual Report and Accounts, including Quality Report, Annual Governance Statement and Letters of Representation**
The Chair asked Ian Knight, Chair of the Audit Committee to update the Board on the discussions at the Audit Committee and the recommendations the Committee had agreed to bring to the Board.

Ian Knight, Chair of the Audit Committee reported on the discussions that had taken place at the Audit Committee. He advised that the Committee had received a draft set of papers that included the Annual

Report and Accounts 2018/19 which included: the forward from the Chair and Chief Executive and sections prescribed by NHS Improvement in the FTARM guidance; including the Annual Governance Statement; Quality Report; and the Annual Accounts.

Ian Knight advised that discussion at the Committee had identified a number of suggested amendments to the reports and these would be addressed prior submission date.

Ian Knight reported that the Committee had also received from the External Auditor, KPMG the ISA 260 report which set out the key findings of the audit and letters of representation and advised that the Trust, as with last year, had prepared the accounts on a going concern basis.

Ian Knight, as Chair of the Audit Committee recommended the Annual Report and Accounts 2018/19 together with the letters of representation for approval.

The Chair thanked Ian Knight for his verbal report from the Audit Committee meeting and sought the board's approval.

The Board after consideration of the papers presented to it and following recommendation from the Audit Committee approved the Annual Report and Accounts 2018/19, which would be subject to amendment prior to submission to NHS Improvement and approved the letters of representation. The Board noted that the final submission date for the Annual Report and Accounts to NHS Improvement was Wednesday 29 May 2019.

099 Corporate Governance Statement (FT4) of the Trust Provider Licence

The Trust Secretary presented the paper setting out the criteria that the Trust assesses itself against when reviewing the Corporate Governance Statements containing in the Provider Licence. He reported that in addition the Trust was required to describe the ways in which it was able to assure itself of the validity of its Corporate Governance Statement in its Annual Governance Statement (AGS), which had been approved earlier in the meeting.

The Board approved the FT4 submission for publication on the Trust website in accordance with the requirements of the Provider Licence

100 Any other business

None

101 Review of risk impacts of items discussed

The Board noted that the risks had been discussed during the meeting.

102 Review of meeting

Conduct of the meeting was very good and kept to time.

The Chair thanked the Board and attendees for their diligence during the approval process.

Date and time of next meeting

Thursday 4 July 2019.

**Agenda Item 2019/100**

Liverpool Women's NHS Foundation Trust

TRUST BOARD
4 July 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 | See agenda its 2019/108 |
| 2 May 2019 | 2019/067 | The Director of Nursing and Midwifery to follow up the Fair and just Culture to be considered against a serious incident in parallel with the investigation and report the findings to the Quality Committee for assurance. | Director of Nursing and Midwifery | Completed | This action has been added to the Quality Committee Action plan for July 2019 |
| 2 May 2019 | 2019/073 | The Acting Medical Director and Director of Nursing and Midwifery to map out where the Trust was able to input along the 'Starting Well' Trainline for review by the Quality Committee. | Acting Medical Director and Director of Nursing and Midwifery | Completed | This action was added to the Quality Committee agenda for June 2019. See Quality Committee Chairs Report for 24 June 2019; agenda item 2019/105 |

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| | 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 | 2019/102 |
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| MEETING | Board of Directors |
| PAPER/REPORT TITLE: | Chief Executive Report |
| DATE OF MEETING: | Thursday, 04 July 2019 |
| ACTION REQUIRED | Information |
| EXECUTIVE DIRECTOR: | Kathy Thomson, Chief Executive |
| AUTHOR(S): | Colin Reid, Trust Secretary |
| | |
| STRATEGIC OBJECTIVES: | *Which Objective(s)?*<br>1. To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☒<br>2. To be ambitious and ***efficient*** and make the best use of available resource ☒<br>3. To deliver ***safe*** services ☒<br>4. To participate in high quality research and to deliver the most ***effective*** Outcomes ☒<br>5. To deliver the best possible ***experience*** for patients and staff ☒ |
| LINK TO BOARD ASSURANCE FRAMEWORK (BAF): | *Which condition(s)?*<br>*1. Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒<br>*2. Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒<br>*3. The Trust is not financially sustainable beyond the current financial year……* ☒<br>*4. Failure to deliver the annual financial plan ……* ☒<br>*5. Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒<br>*6. Ineffective understanding and learning following significant events……* ☒<br>*7. Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒<br>*8. Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒ |
| CQC DOMAIN | *Which Domain?*<br>***SAFE-*** *People are protected from abuse and harm* ☐<br>***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐<br>***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐<br>***RESPONSIVE –*** *the services meet people's needs.* ☐<br>***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.* ☐ |

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| | *ALL DOMAINS* ☒ | | | |
| LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT | 1. Trust Constitution ☒<br>2. Operational Plan ☒<br>3. NHS Compliance ☒ | | 4. NHS Constitution ☒<br>5. Equality and Diversity ☒<br>*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 receive 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*


Nursing Times Award: I am delighted to announce that one of our Nurse Leaders has been shortlisted in the 2019 Nursing Times Awards. Sharon Owens has worked within the NHS for 40 years and is the Ward Manager of the Gynaecology Emergency Department (GED) and Early Pregnancy Unit (EPAU) at the Trust. Sharon displays a true leader attitude going above and beyond her duties to ensure that staff and women using the services feel supported and listened to and is closely involved with decision making, service development, staff training and personal development plans. Sharon has had a very exciting and passionate career; she always puts patient's care and their experiences at the forefront. She is an advocate for patient safety and actively encourages staff to report and learn from incidents within a no blame culture. As a mental health first aider, Sharon demonstrates the importance of health and wellbeing within the workplace and is the first to support and encourage staff through difficult experiences.

Sharon's longstanding commitment to patients and staff was recognised this year at the Trusts annual staff awards evening when Sharon received my Chief Executive's outstanding contribution award.

Interim Chief Information Officer : Welcome Sandra Goulden to the Trust as interim Chief Information Officer reporting to the Director of Finance. Sandra is undertaking this role in a full time capacity until a substantive CIO is in place, the recruitment process for which will begin shortly. David Walliker will continue to support the Trust over the next few months with a number of challenges. Sandra has recently worked as Interim Chief of Digital and Innovation at North West Ambulance Services and has worked as the IT Lead for Liverpool Community Health. Previously to this Sandra worked for IT services at Manchester Metropolitan University and the University of Cumbria.

Division of Family health - Danika Heyes won maternity support worker of the year at the MAMA awards from over 800 nominations and Enhanced Team leader, Carmel Doyle received high praise when presented at Westminster for her work in Knowsley as an exemplar for joint working. - Well done to Danika and Carmel

The breast-feeding team are achieving amazing results of 63% at initiation which prepares the Maternity service for UNICEF BFI re- accreditation.

Hewitt Fertility Centre: The Trust launched a sperm and egg donor campaign in June with the Hewitt Fertility Centre. The aim is to recruit more donors who can help families who need donor sperm or eggs as part of their fertility treatment. It is hoped that a successful donor campaign will address the local shortage of donors.

Patient and Visitors access to Trust: The Trust has kept patients, visitors and staff informed recently on the increasing progress of the Neonatal Unit redevelopment which is entering a key phase of the project as can be seen by the growth of the main build structure outside. In addition to the actual build the Trust has made efforts to keep people informed about the temporary disruption to car parking. This initial disruption is part of an overall improvement of car parking facilities which will also soon be complemented by a new ANPR car parking system.

Safeguarding: The Trust will be holding a Multi-Agency event 26th September 2019 . There will be a number of guest speakers including Merseyside Chief Constable, Area Commander for Serious organised Crime and we are honoured to have Laura Richards to speak. Laura Richards is a victims advocate and Criminal Behavioural analyst and is the founder of the world's first dedicated advocacy service for stalking victims in the UK. Laura Richards has also appeared on Channel 4 about the potential risks of social media and on- line dating websites as well as other various TV programmes. Laura has won numerous awards for her work and we are extremely fortunate that she has agreed to speak at the event. Details of the day will be circulated in due course.

Listeria alert: The Trust received an alert in relation to Listeria and the good food company in May 2019. The information was cascaded immediately, and the Trust received confirmation that sandwiches from the named supplier were not stocked or served (either by OCS or other outlets at the Trust) therefore there was no risk to patients, visitors or staff from this incident.

NHS Interim People Plan: In January 2019 the NHS published its Long Term Plan which sets out a 10-year vision for healthcare in England. The NHS Interim People Plan (published in June 2019) sets out the NHS vision for people who work for the NHS, to enable them to deliver that NHS Long Term Plan, with a focus on some immediate actions.

The Interim People Plan states that to deliver the vision set out in the NHS Long Term Plan, the NHS will need more people working for it over the next 10 years, across most disciplines and in some new ones yet to be defined – different people in different professions working in different ways. The Plan recognises the need to promote positive cultures, build a pipeline of compassionate and engaging leaders and make the NHS an agile and modern employer if it is to attract and retain the people it needs for the future sustainability of the service.

The Plan sets out the following Key themes and encourages Boards to have these in their line of sight:

- Making the NHS the best place to work – we must make the NHS an employer of excellence – valuing, supporting, developing and investing our people.

- Improving our Leadership Culture – positive, compassionate and improvement focussed leadership creates the culture that delivers better care.
- Addressing Urgent Workforce Shortages in Nursing there are significant staff shortages across the country in many parts of our workforce; however, shortages in nursing are the single biggest and most urgent we need to address.
- Develop a workforce to deliver 21st century care - we will need to grow our overall workforce, but growth alone will not be enough. We need a transformed workforce with a more varied and richer skill mix, new types of roles and different ways of working, ready to exploit the opportunities offered by technology and scientific innovation to transform care and release more time for care
- Develop a new operating model for workforce - we need to continue to work collaboratively and to be clear what needs to be done locally, regionally and nationally with more people planning activities undertaken by local integrated care systems (ICSs).

The fully costed and finalised NHS People Plan is anticipated by the end of the year.

Trust digital maturity HSJ: Trusts were asked to rate their digital maturity out of 100 against three measures: readiness, existing capabilities, and enabling infrastructure. HSJ has taken an average on these three measures to create an overall digital maturity score out of 100 for each trust (see the full lists of all trusts here). I am please to report that Liverpool Women's comes in the Top 10 digital maturity trusts. See appendix 1.

*SECTION B – Local*

University of Liverpool Commitment to Liverpool City Region: The University of Liverpool has collated a report showing its commitment to Liverpool City Region (LCR) as an economic catalyst, a key employer and a driver for health, culture, heritage and innovation. University Vice Chancellor Professor Dame Janet Beer launched the publication, *Celebrating the University of Liverpool's Contribution to Liverpool City Region* at a special event attended by the great and good from across Merseyside. See appendix 2.

The new Royal Liverpool Hospital: Work is set to start on an essential programme of repairs to parts of the structure of the new Royal, which will ensure the hospital is finished to the high standards required. Over the last year a thorough structural review of the building has been carried and solutions identified where it found issues in the original design that need to be rectified. short film to explain these works. Work on the structural interventions will in June.

Cheshire and Merseyside Health and Care Partnership: Following the departure of Aidan Kehoe as the representative on C&M System Management Board for the constituency of 'Acute and Specialist providers', Ann Marr, CEO of St Helens and Knowsley NHS Trust is confirmed as its new representative.

*SECTION C – National*

Appointment of Amanda Pritchard as NHS' Chief Operating Officer and Chief Executive of NHS Improvement: Attached a letter at appendix 3. from Simon Stevens, Chief Executive, NHS England and Baroness Dido Harding, Chair, NHS Improvement about the appointment of Amanda Pritchard as NHS' Chief Operating Officer and Chief Executive of NHS Improvement.

FOR HEALTHCARE LEADERS
HSJ

# The Download: Trust digital maturity revealed at last

By Ben Heather | 25 June 2019

**The fortnightly newsletter that unpacks system leaders' priorities for digital technology and the impact they are having on delivering health services. Contact Ben Heather in confidence here.**

More than a year after they were collated, *HSJ* can reveal the second round of digital maturity assessments for 233 trusts across the country.

In theory, the NHS England-run survey provides the first opportunity to track, trust by trust, how digital maturity in the NHS has improved over time. The first assessments, conducted in late 2015 and published in April 2016, revealed wide variation in digital maturity across NHS providers. This second set should show how far each provider has come, whether the hundreds of millions of pounds invested in NHS IT since has been well spent, and where future investment is needed.

Unfortunately, it is not that straightforward.

First off, the assessments are now about 18 months old. Trusts completed the second round of survey in Autumn 2017 and the result has been available in the piecemeal form

within the NHS since early 2018. NHS England only released the assessments at all after *HSJ* appealed to the Information Commissioner's Office. A third round is meant to start this summer but it's anyone's guess when it will be published.

Secondly, they are self-assessments, with trusts essentially marking their own homework. This creates both a benchmarking problem (not every trust answers the same questions the same way) and the risk that trusts will inflate/deflate their score in the hope of gain access to central IT funding.

The Nuffield Trust examined the second-round digital maturity assessments when compiling its report on NHS IT, published last month. Researchers concluded structured interviews with senior trust IT managers were a more reliable gauge of progress on digital maturity. Other researchers have expressed similar reservations about its reliability.

In short, the assessment should be taken with more than a pinch of salt.

Nevertheless, the assessments are still the clearest and most up-to-date measure of trust digital maturity the NHS has. They have also played a major role in deciding where hundreds of millions of pounds in central IT funding have been spent and so, even though deeply flawed, remain important.

This is what they tell us.

## A rising tide

Like the 2015-16 assessment, trusts were asked to rate their digital maturity out of 100 against three measures: readiness, existing capabilities, and enabling infrastructure. *HSJ* has taken an average on these three measures to create an overall digital maturity score out of 100 for each trust (see the full lists of all trusts here).

The figures show that between autumn 2015 when the first survey was run and autumn 2017 when the second survey was run, the average digital maturity score for trusts rose from 60 to 70. This direct comparison should be treated with caution, especially at the trust level. Some of the wilder swings in digital maturity scores at a trust level could be down to a change in the person filling in the survey as much as a change in circumstances.

Overall then, trusts rated themselves relatively well for “readiness” to go digital (81.6), that is the ability to plan and strategise for new technology, and enabling infrastructure (76.4). Trusts rated themselves less well on existing tech capability (53.3), although this was a marked improvement from 2015 (40.4).

There were a few exceptions. Twenty-four trusts self-reported lower digital maturity in 2017 than two years prior. Among them were two global digital exemplar trusts (Royal Free London FT, and Newcastle Upon Tyne FT), trusts that, at the time and since, received millions in additional central funding for digital technology to become “exemplars” for the rest of the NHS to follow. Northern Lincolnshire and Goole FT reported the biggest slide, judging itself to be 30 per cent less mature. The trust is in financial and quality special measures and in 2016 was infected with ransomware, leading to cancellations of thousands of appointments.

## The head and tail

**Top 10 digital trusts**

| | | | | | |
|---|---|---|---|---|---|
| **Cambridge University Hospitals NHS Foundation Trust** | **99** | **92** | **97** | **288** | **96.00** |
| Salford Royal NHS Foundation Trust | 99 | 88 | 98 | 285 | 95 |
| Wirral University Teaching Hospital NHS Foundation Trust | 98 | 88 | 98 | 284 | 94.7 |
| North Tees and Hartlepool NHS Foundation Trust | 96 | 89 | 98 | 283 | 94.3 |
| University Hospitals Birmingham NHS Foundation Trust | 98 | 81 | 97 | 276 | 92 |
| Royal Cornwall Hospitals NHS Trust | 91 | 81 | 98 | 270 | 90 |
| Bradford Teaching Hospitals NHS Foundation Trust | 99 | 77 | 93 | 269 | 89.7 |
| Royal Liverpool and Broadgreen University Hospitals NHS Trust | 95 | 82 | 90 | 267 | 89 |
| City Hospitals Sunderland NHS Foundation Trust | 97 | 79 | 88 | 264 | 88 |
| Liverpool Women’s NHS Foundation Trust | 97 | 69 | 97 | 263 | 87.7 |

Cambridge University Hospitals FT, with its hundreds of millions invested in digital technology, has pipped Salford Royal FT as the most digitally mature trust in the country (at least in its own estimation).

Five of the top ten trusts in 2017 were there in 2015, and many of those that dropped out are lurking not far below on the list. Six of the trusts are global digital exemplars, and two are fast follower trusts (Liverpool Women’s and North Tees and Hartlepool). Only Bradford Teaching and Royal Cornwall are not part of the GDE programme. Coincidentally both have reported a major increase in digital maturity of 30 and 41 points respectfully taking them from middling trusts to among the top of the pack.

**Bottom 10 digital trusts**

| | | | | | |
|---|---|---|---|---|---|
| **Staffordshire and Stoke on Trent Partnership NHS Trust** | **51** | **35** | **73** | **159** | **53.00** |
| Norfolk and Norwich University Hospitals NHS Foundation Trust | 64 | 34 | 57 | 155 | 51.7 |
| North Cumbria University Hospitals NHS Trust | 66 | 29 | 59 | 154 | 51.3 |
| Avon and Wiltshire Mental Health Partnership NHS Trust | 65 | 31 | 54 | 150 | 50 |
| West Hertfordshire Hospitals NHS Trust | 64 | 31 | 54 | 149 | 49.7 |
| Barts Health NHS Trust | 58 | 44 | 42 | 144 | 48 |
| North Middlesex University Hospital NHS Trust | 58 | 31 | 48 | 137 | 45.7 |
| Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust | 50 | 25 | 60 | 135 | 45 |
| Buckinghamshire Healthcare NHS Trust | 50 | 42 | 42 | 134 | 44.7 |
| London Ambulance Service NHS Trust | 40 | 30 | 58 | 128 | 42.7 |

At the lower end, there has been a bigger shift, with only three trusts (London Ambulance Service, Queen Elizabeth Hospital King's Lynn FT and Barts Health Trust) appearing in 2015 and 2017. Both Barts Health and London Ambulance have reported severe problems with basic IT in recent years, with the former the worst affected by WannaCry cyber attack and the latter struggling with its ageing dispatch system at the time of assessment.

However there also some signs of progress at the bottom end of digital maturity, with all but two of these trusts (North Middlesex and Buckinghamshire Healthcare) reporting improvements in digital maturity since 2015.

## The have-nots get some

One of the major criticisms of NHS England's global digital exemplar programme, launched in 2016 to kick-start the latest attempt at trust digitisation, was that it financially rewarded the digitally advanced and did nothing for half of trusts that remained heavily dependent of ageing IT systems and warehouses full of paper records.

However, if the latest self-assessments are to be taken on face value the opposite has occurred. An *HSJ* analysis shows that overall trusts with relatively poor digital maturity in 2015 reported improving significantly more, on average than trusts with relatively highly digital maturity in 2015. For instance, the bottom 50 rated trusts in 2017 had, on average, a digital maturity score of 55, 12 points higher than in 2015. In contrast, the top 50 trusts increased their average digital maturity score to 85.2 over the same period and improve 7.9 points. Even the chosen 23 global digital exemplars trusts reported less

improvement over the period (8.4 points) than the bottom 50 trusts. All this suggests that, rather than a handful of “exemplar” trusts streaking ahead of their digitally impoverished peers, the gap has narrowed.

## Why might this be?

It could partly be down to gaming. The way the exemplar funding model favours more digitally advanced trusts first itself could have skewed scores. It’s impossible to prove one way or another but some less advanced trusts may have boosted their scores in the hope of becoming an exemplar or fast follower.

Another possibility is the timing. The less digitally advanced trusts received extra cyber security funding in the wake of the 2016 WannaCry attack (Barts Health, for instance, received £3.5m in 2016-17, more than any other trust), boosting their digital maturity score from a low base. While the majority of digital exemplar trusts had received some central funding by autumn 2017, for most the programme was still at an early stage. Another argument: it is simply easier for less digitally advanced trusts to make substantial improvement by introducing basic IT systems. Further up the digital maturity ladder improvements may become more incremental, difficult and risky.

## Report demonstrates University commitment to Liverpool City Region

The University of Liverpool has collated a report showing its commitment to Liverpool City Region (LCR) as an economic catalyst, a key employer and a driver for health, culture, heritage and innovation.

University Vice Chancellor Professor Dame Janet Beer launched the publication, ***Celebrating the University of Liverpool's Contribution to Liverpool City Region*** at a special event attended by the great and good from across Merseyside.

Written by Professor Dinah Birch, University Pro-Vice-Chancellor for Cultural Engagement and Professor Michael Parkinson, University Pro-Vice-Chancellor for Civic Engagement, it highlights the economic contribution made by the institution; including £152m paid as taxation each year, the £73m spent with local firms through procurement, students' £342m injection into the regional economy, as well as £652m of gross value added to LCR by the University.

But it also looks ahead to some key developments across health, employment, innovation, and leadership and culture.

A founding member of Liverpool Health Partners (LHP), the University's game-changing Liverpool Head and Neck Centre will provide head and neck cancer sufferers with access to the latest research, while the Liverpool Centre for Cardiovascular Science will bring LHP experts together to advance cardiovascular disease and stroke research.

The University's Pre-Apprenticeship programme has seen 36 participants complete the scheme from inception, and almost 200 young people have gained employment in a variety of sectors across the LCR since the launch of the University's Apprenticeship Programme in 2011.

Elsewhere, the Scholars Programme helps local students gain access to higher education, and IntoUniversity North Liverpool – co-funded by University alumni donations – provides academic support to as many as one thousand local students every year.

On the University's border, Knowledge Quarter Liverpool will soon be home to the Royal College of Physicians as well as University of Liverpool International College, a partnership with Kaplan that will deliver 35,000 sq ft of education and learning facilities.

On campus, the Digital Innovation Factory (DIF) will boost the LCR economy by £44.5m as a centre of excellence in simulation and virtual reality. It follows the £81m investment in the Materials Innovation Factory (MIF), which is fuelling innovation through the shared use of scientific infrastructure and expertise; and Sensor City, a distinct, collaborative space for sensors and sensor systems innovation developed in partnership with Liverpool John Moores University.

Often setting the agenda for the LCR, the University's Heseltine Institute for Public Policy, Practice and Place has delivered key reports on the social economy, housing provision, retail regeneration, graduate mobility, inclusive growth and harnessing the Mersey to generate energy.

The Institute of Cultural Capital's work around Liverpool's Capital of Culture year has seen the city become the template for future culture capitals, while partnerships with Tate Liverpool and National Museums Liverpool have brought University research and insight to whole new audiences.

The University is committed to developing and deepening these practices and principles even further by creating a Civic University Agreement with key LCR organisations.

Professor Birch said: "We've identified the many ways in which staff and students already contribute to the health, wellbeing and economic success of the LCR and are delighted that the new Civic University Agreement recognises the value of this work and encourages its future development."

Professor Parkinson said: "We will continue to lead the public debate about the future development of the city region.

"We will put the intellectual and social capital at the disposal of city regional leaders.

"We will continue to invest, educate, offer opportunity and remain open in a global world.

"We welcome more partnerships with more organisations.

“Our commitment for today and for the future matches and reinforces that made by the founders of the University.”

To read the full report, please visit: www.liverpool.ac.uk/civic-engagement

**NHS England and NHS Improvement**
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

**To:**
NHS trust and NHS foundation trust chairs and chief executives
CCG Accountable Officers
STP and ICS leads

5 June 2019

Dear colleagues

**Amanda Pritchard appointed NHS' Chief Operating Officer and Chief Executive of NHS Improvement**

We are delighted to announce today that Amanda Pritchard has been appointed as the NHS' Chief Operating Officer. She is currently Chief Executive of Guy's and St Thomas' NHS Foundation Trust in London. The appointment follows an open competitive selection process and Amanda will take up post full time on 31 July.

The new NHS chief operating officer post is directly accountable to the NHS chief executive Simon Stevens, and serves as a member of the combined NHS England /NHS Improvement national leadership team. The COO oversees NHS operational performance and delivery, as well as implementation of the service transformation and patient care improvements set out in the NHS Long Term Plan. The COO is also accountable to the NHSI Board as NHS Improvement's designated accountable officer with regulatory responsibility for Monitor.

Simon Stevens said: "This important appointment is integral to creating the newly combined NHS England and NHS Improvement, able to lead the next phase of the NHS' development. Amanda will play a critical role in supporting further progress on quality of care, health outcomes and efficiency, as well as operational performance and delivery."

Amanda Pritchard said: "It is a huge privilege to be joining NHS England and NHS Improvement at this exciting time and to have the opportunity to influence the NHS agenda and help deliver the Long Term Plan. In doing so, I know that I will draw upon my experience leading Guy's and St Thomas' where our strong values and

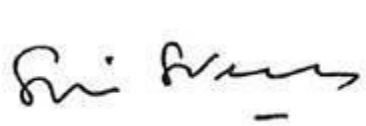
focus on the needs of our patients and staff is always at the heart of decision making."

Amanda joined the NHS through its graduate management training scheme in 1997 and has held a variety of NHS management posts since then including at West Middlesex Hospital, and as Deputy Chief Executive of Chelsea and Westminster Hospital. She has also served as health team leader in the Prime Minister's Delivery Unit. Amanda currently also serves as chair of the Shelford Group of teaching hospitals and is a trustee of the NHS Providers trade association.

Chair of NHS Improvement Baroness Dido Harding said "I'm delighted to welcome Amanda as NHS Chief Operating Officer/NHS Improvement chief executive. She has a fantastic track record as CEO of one of the largest trusts and will bring tremendous leadership and operational experience as we implement the NHS Long Term Plan."

Chair of Guy's and St Thomas' Sir Hugh Taylor said "This is a great honour for Amanda and good news for the NHS. Amanda has played an active leadership role in the wider health system here in south east London, so understands the need for new ways of working that move beyond traditional organisational boundaries. While we will miss her talent, energy and vision, Amanda will be a great asset to the national team."

Yours sincerely



Simon Stevens

**Chief Executive, NHS England**

Baroness Dido Harding

**Chair, NHS Improvement**

2019/103

Board of Directors
Committee Chair's report of Audit Committee meeting held 16 May 2019

1. Meeting Quorate: Yes

2. Agenda items covered
   - Head of Internal Audit Draft Opinion: The Committee received the final Head of Internal Audit Opinion and noted the opinion provided Substantial Assurance that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are being applied consistently.

   - External Audit Findings & Management letter – Draft (ISA260) & Letters of Representation: The Committee received the draft External Audit ISA 260 noting that overall there was no outstanding matters from the audit of the Accounts and Annual Report; however at the time of receipt of the ISA 260 there were a number of matters where work was ongoing and this would be concluded before the report was to be signed off for submission to NHS Improvement. The Committee noted that as with previous years the audit opinion had been based on the Trust as a going concern.

   - NHS Improvement Code of Governance: The Committee received the outcome of a review on compliance with the code of governance and confirmed that for the year 2018/19 the trust complied with the provisions of the Code with the exception of Code provision B.1.2: which related to: at least half the board of directors, excluding the chairperson, should comprise non-executive directors determined by the board to be independent. The Committee noted that during the year 2018/19, the trust was non-compliant with regards to the number of non-executive directors to executive directors for a period from 28 September 2018 to 1 March 2019. This was due to the resignation of a non-executive director inside his term of office which reduced the number of non-executive directors from six to five whilst the trust had in post six executive directors. The council of governors undertook an open and transparent appointment process to appoint to two additional non-executive directors who were appointed from 1 March 2019.

   - Annual Report, Financial Accounts & Quality report 2018/19 including Annual Governance Statement – The Committee received and approved the Annual Report, Financial Accounts & Quality report 2018/19. The Committee approved the Annual Reports and Accounts 2018/19 noting that the Annual Report and the Quality Report were subject to amendment prior to sign off and submission to NHS Improvement. Subject to the amendments the Committee recommended Annual Report, Financial Accounts & Quality Report 2018/19 including Annual Governance Statement for approval at a convened meeting of the Board on 16 May 2019.

3. Board Assurance Framework (BAF) risks reviewed
   - None

4. Escalation report to the Board on Audit Performance Measures
   - None

5. Issues to highlight to Board
   - None

## 6. Action required by Board

~ Approval of Annual Report, Financial Accounts & Quality Report 2018/19 including Annual Governance Statement at the meeting of the Board held on 16 May 2019.

Ian Knight
Chair of Audit Committee
June 2019

2019/104(i)

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 24 June 2019

1. Was the quorate met? Yes

2. Agenda items covered

~ Operational Performance Month 2 2019/20 including RTT and Cancer Targets: The Committee received an update on Operational Performance at Month 2 2019/20. The Committee noted that challenges continue in achieving cancer and RTT targets. The Committee heard that a regional approach to managing the gynae-oncology 62day treatment target was underway with support from the Cancer Alliance. NHSI IST had provided re-assurance that the Trust was managing the RTT performance in the most clinically appropriate manner and were satisfied with progress made to date.

Following concerns expressed by the Committee at the April & May meetings, the Committee noted that trajectories were being put together to demonstrate anticipated performance against target for the remainder of the year and the interdependencies of achieving the trajectory such as consultant recruitment and sickness would be mapped to demonstrate potential impact against trajectory. The Committee would receive the trajectories for RTT and Cancer at its July meeting.

~ Finance Performance Review Month 2 2019/20 including CIP: The Committee received Month 2 2019/20 finance position noting that at Month 2 the Trust was reporting a deficit of £0.6m against a deficit budget of £0.4m, giving a year to date adverse variance of £0.2m. The forecast for the year has been maintained at the breakeven plan, at this early stage in the year, although the Committee noted the risks continued in delivering the breakeven year end position. The Committee received assurance on management and delivery of the Month 2 financial position.

~ Post Implementation Review of Cost Improvement 2018/19: The Committee received the Cost Improvement Programme 2018/19: Full Year Post Implementation Review. The Committee noted that the Trust's delivered the £3.6m Cost Improvement Programme for 2018/19 in full although £2.0m was on a non-recurrent basis, as a consequence the Committee noted that the non-recurrent element of delivery was included in operational planning and budget setting for 2019/20. The Committee recognised the risks of delivery of the CIP for 2019/20 and received assurance on the management of the risks. One scheme implemented had an adverse impact on quality and the Committee was assured that mitigation was in place to ensure that the impact did not continue into 2019/20.

~ Strategic Outline Case: The Committee received an update on the work being undertaken to advance the strategic case. The Committee noted the steps to be performed arising from the clinical summit held on 11 June 2019 and financial position of the Trust.

~ IM&T Update: The Committee received a verbal update from the interim Chief Information Officer on the development of the Trust's IM&T strategy and its involvement in the EPR programme and was assured that actions were being taken to mitigate and manage IM&T risks.

- **Single Neonatal Service**: The Committee received a presentation on the progress being made in the development of the neonatal surgical service at Alder Hey.

- **Genetics Update:** The Committee noted the current actions being taken with regards to the transfer of staff to Manchester University NHS Foundation Trust which had been delayed and was now targeted to take place by 1 August 2019

- **Neonatal Capital Build Update and Programme Annual Report 2018/19:** The Committee received an update on progress against the plan, noting that the project continued to be on track.

- **National Cost Collection Board Assurance Pre-Submission Report 2018/19:** The Committee reviewed and approved the National Cost Collection Board Assurance Pre-Submission Report 2018/19 which would be submitted to NHS Improvement in August 2019.

- **Board Assurance Framework:** The Committee reviewed the risk that it was accountable for within the BAF and agreed that there were no amendments that needed to be made to the text or risk scores.

- **Sub Committee Chairs reports received:**
  - Digital Hospital Sub-Committee– nothing to highlight.

3. **Board Assurance Framework (BAF) risks reviewed**
   No new risks identified. No changes to existing risks identified.

4. **Escalation report to the Board on Performance Measures**
   None – but note RTT and Cancer referred above.

5. **Issues to highlight to Board**
   -

6. **Action required by Board**
   No actions required.

Jo Moore
Chair of FPBD
June 2019

2019/104(ii)

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 20 May 2019

1. Was the quorate met? Yes

2. Agenda items covered

~ Operational Performance Month 1 2019/20 including RTT and Cancer Targets: The Committee received an update on Operational Performance at Month 1 2019/20. The Committee noted that the data provided for RTT and Cancer was not validated due to the timing of the meeting. Referring to the provision of trajectories for RTT and Cancer the Interim Director of Operations reported that her expectation was that these would be available at the July meeting. The Committee was not assured, at this time, on delivery of the cancer and RTT national targets for 2019/20.

~ Finance Performance Review Month 1 2019/20 including CIP: The Committee received Month 1 2019/20 finance position noting that at Month 1 the Trust was reporting a deficit of £0.4m against a deficit budget of £0.3m, giving a year to date adverse variance of £0.1m. The Committee noted the risks in delivering the breakeven year end position and received assurance on management and delivery of the Month 1 financial position.

~ Neonatal Capital Build Update: The Committee received assurance on the progress made in the redevelopment of the Neonatal Unit and approved the recommendation to the Board for the capital spend for the Site-Wide Electrical Infrastructure Programme.

~ IM&T Update: The Committee received a verbal update from the Chief Information Officer on the development of the Trust's IM&T strategy and the Trust's involvement in the EPR programme and was assured that actions were being taken to mitigate and manage IM&T risks.

~ Board Assurance Framework: The Committee reviewed the risk that it was accountable for within the BAF and agreed that there were no amendments that needed to be made to the text or risk scores.

~ Sub Committee Chairs reports received:
  - Digital Hospital Sub-Committee– nothing to highlight.
  - Emergency Planning Resilience & Response Committee – nothing to highlight.

3. Board Assurance Framework (BAF) risks reviewed
No new risks identified. No changes to existing risks identified.

4. Escalation report to the Board on Performance Measures
None – but note RTT and Cancer referred above.

5. Issues to highlight to Board
None

## 6. Action required by Board

Approval of the capital works for the upgrade of the Site-Wide Electrical Infrastructure noting its inclusion in the approved capital programme for 2019/20. Under the Trust's SFIs the Committee agreed to recommend the expenditure for Board approval.

Jo Moore
Chair of FPBD
May 2019

2019/105(i)

Board of Directors

Committee Chair's report of Quality Committee meeting held 24 June 2019

1. Was the quorate met? Yes

2. Agenda items covered

~ Chair's Announcement: The Chair reported on the Clinical Summit held at the Trust on 11th June 2019. Members of the Committee who attended the Summit commented on the success of the event and that it had been well attended by staff, other healthcare providers from the city, Commissioners, NHS England/Improvement and the CQC. The outcome from the summit would be discussed at Board.

~ Board Assurance Framework – Quality Related Risks: The Committee reviewed the Quality related BAF risks and received assurance that the risks attributed to the Committee were being managed appropriately.

~ Subcommittee Chairs reports: The Committee received chairs reports from each of its senates/committees: Safety Senate; Effectiveness Senate; Experience Senate; Hospital Safeguarding Board; and Corporate Risk Committee. The Committee had noted that there were no matters that had been escalated to the Committee for review. Several matters were discussed from the reports and the Committee was assured that each of its reporting committees were discharging their duties and responsibilities.

~ CQC Inspection Action Plan: The Committee received assurance on the progress being made against the CQC inspection action plan.

~ Monthly Quality Performance Review M2 2019/20: The Committee received an update on Operational Performance at Month 2 2019/20. The Committee noted that challenges continue in achieving Cancer and RTT targets. The Committee heard that a regional approach to managing the gynae-oncology 62day treatment target was underway with support from the Cancer Alliance. NHSI IST had provided re-assurance that the Trust was managing the RTT performance in the most clinically appropriate manner and were satisfied with progress made to date.

Following concerns expressed by the Committee at the April/May meeting, the Committee noted that trajectories were being put together to demonstrate anticipated performance against target for the remainder of the year and the interdependencies of achieving the trajectory such as consultant recruitment and sickness would be mapped to demonstrate potential impact against trajectory. The Committee would receive the trajectories for RTT and Cancer at its July meeting.

~ Research and Development Annual Report 2018/19: The Committee received the Research and Development Annual Report 2018/19 and noted that last year had been very successful in the delivery of the Trust's Research Strategy. The Committee was also assured that the Trust was working collaboratively with city wide partner organisations, in particular the Trust's participation in the LHP starting Well programme. The Committee also supported the proposal

from the Director of Research that he looks to have informal meeting of a research committee to enable better engagement across the Trust.

~ **Health and Safety Annual Report 2018/19:** The Committee received the Health and Safety Annual Annual Report 2018/19 and there was some concern that the IOSH Health and safety training had not been as well attended as it should be with some staff stating they would attend but then did not; however, since the publication of the report progress had been made to ensure improved attendance in 2019/20.

~ **LocSSIPs Assurance Report:** The Committee received the most recent LocSSIPs assurance report and noted progress to date. The Committee agreed that a further assurance report would be provided to the Committee in September which would include the findings of the MIAA internal Audit Review and action plan and thereafter on a quarterly basis. The Committee received assurance on the progress of the work of the LocSSIPs implementation group.

~ **LHP Starting Well:** The Committee noted the action from the Board meeting in May relating to the mapping out where the Trust was able to input along the 'Starting Well' Trainline. The Committee noted that the Director of Nursing and Midwifery and Medical Director were awaiting further information from LHP to inform further on how this action could be undertaken and agreed to further review the position at its meeting in September 2019.

~ **Annual Complaints Report 2018/19:** The Committee received the Annual Complaints Report 2018/19 and was pleased to note the number of formal complaints had reduced from 2017/18. The main theme arising from the complaints relate to the way staff communicate with patients and the Committee was pleased to see that the Trust was exploring training to be put in place to support better communication and engagement.

3. **Board Assurance Framework (BAF) risks reviewed**
   No new risks identified. No changes to existing risks identified.

4. **Escalation report to the Board on Performance Measures**
   None – but note RTT and Cancer referred above.

5. **Issues to highlight to Board**
   None.

6. **Action required by Board**
   None

Susan Milner
Chair of Quality Committee
June 2019

2019/105(ii)

Board of Directors

Committee Chair's report of Quality Committee meeting held 20 May 2019

1. Was the quorate met? Yes

2. Agenda items covered

~ Board Assurance Framework – Quality Related Risks: The Committee reviewed the Quality related BAF risks and received assurance that the risks attributed to the Committee were being managed appropriately and noted that two risks had been closed and removed from the BAF as agreed at Board. They related to 2168 – best clinical outcomes relating to the strategic objective "To participate in high quality research and to deliver the most effective outcomes" and 2167 – Positive Patient Experience relating to the strategic objective "To deliver the best possible experience for patients and staff"

~ CQC Inspection Action Plan: The Committee received assurance on the progress being made against the CQC inspection action plan. Future reports would be presented on a "by exception basis".

~ Monthly Quality Performance Review M12: The Committee received an update from the Interim Director of Operations (Interim) and received assurances on arrangements being put in place to address training requirements across the Trust with regard to RTT. The Committee had noted the concerns expressed by FPBD regarding the lack of information surrounding the trajectory to deliver RTT and Cancer national targets and had sought assurance from the Interim Director of Operations that by the July meeting the committees and Board would be in the position of knowing when the Trust would deliver the targets.

~ MIAA Spot check Audits: The Committee was assured that actions were being addressed to improve patient and staff experience and quality and safety for patients within the Bedford Clinic and Gynaecology.

~ Reducing Term Admissions: The Head of Midwifery joined the meeting and provided assurance that the ATAIN element of the CNST action plan was green, and that the Trust was presently on track to deliver the CNST action plan. Concerns were raised regarding safety element 8 relating to the multi-professional training and the Committee noted that this was being monitored by the executive. The Committee received assurance on the actions taken by the Trust to deliver the CNST action plan and the multi-professional training requirements.

~ Inpatient Gynaecology Survey Report: The Committee received the Inpatient Gynaecology Survey Report and noted that it was still not clear whether the Trust was performing better or worse than previous reports. The Committee agreed that the Experience Senate review on behalf the Committee whether the Trust was performing better or worse than previous surveys and report back to the Committee its findings under the Experience Senates Chairs Report

~ Making Every Contact Count: The Committee received and update on making every contact count (MECC) noting that it was an initiative that enables staff to be proactive in facilitating greater awareness to patients and service users of health and wellbeing initiatives. The Deputy Director

of Nursing and Midwifery presented the Trust's action plan and reported that there had been a considerable amount of engagement within the Divisions; with 20 'champions' identified across the Trust to undertake the training. The Committee was assured that the initiative was being implemented across the Trust and had requested that a 6 monthly update be provided.

~ **Adult Mortality and Perinatal report Q4:** The Committee received assurance from the report on the learnings from adult and perinatal mortality.

~ **Review of performance against the Quality Strategy (Q4):** The Committee noted the Trust's performance against the quality strategy and the two areas for improvement. The Committee was pleased to note that work had started on the 2020/24 Quality Strategy which would be brought to the Committee of January 2020.

~ **Equality & Human Rights Goals 1&2 – review of progress:** The committee received assurance that the Trust was progressing well against delivery of the goals as set out in the paper.

3. **Board Assurance Framework (BAF) risks reviewed**
   No new risks identified. No changes to existing risks identified.

4. **Escalation report to the Board on Performance Measures**
   None – but note RTT and Cancer referred above.

5. **Issues to highlight to Board**
   None.

6. **Action required by Board**
   None

Susan Milner
Chair of Quality Committee
May 2019

2019/106

Board of Directors
Chair's report of Putting People First Committee meeting held on 24 June 2019

1. Was the quorate met? YES

2. Agenda items covered
   - Board Assurance Framework: Review of Board Assurance People Risks

   - Staff Story - Delivered by Leanne Gould who secured employment with the Trust having progressed through the Trust's Pre-Employment Programme ran in partnership with the DWP and Southport College.

   - Director of Workforce Report – Update on PPF Strategy; Appointment of Resuscitation Officers; Successful bid to host NHS Graduate Trainee in Operational Management; On track to meet HEE targets for widening participation; Health & Welling activities update; Genomics transfer date deferred due to IT & Governance issues; Junior Doctor contract offer and actions planned to improve junior doctor's working lives @ LWH.

   - NHS Interim People Plan – Review of NHS Interim People Plan and assurance gained that the Trust's People Strategy reflects the key proposals within the national plan. With a focus on making the NHS the Best Place to work, the Trust has commenced its Summer of Listening activities with a listening event and a series of pop up events to engage with staff in their place of work

   - Workforce KPIs Dashboard – KPI was reviewed and assurance gained that Divisions had clear line of sight on improving PDR and Mandatory Training rates and progress would be monitored through Divisional Boards and Divisional Performance Reviews. Clinical Mandatory training was reported in addition to Core Mandatory training. The Committee received the NHSI feedback on the Retention Action Plan, noting that this focused solely on nursing & midwifery retention. The Trust had a target to reduce turnover in the N&M workforce by 1.2% in the next 12 months and was currently on track to achieve this. A deep dive into Trust-wide Sickness Absence was scheduled for the September meeting of PPF Committee.

   - Fair & Just Culture Update – The Committee received an update providing assurance on the Fair & Just Culture programme of work which was progressing in accordance with the agreed project plan and timescales.

   - Disciplinary & Grievances Annual Review – The Committee received an analysis of the disciplinary, grievance and dignity@ work cases in the last financial year. The number of disciplinary cases had reduced from 20 to 12 in the last year, continuing a reducing trend since a peak of 27 cases in 2015. No trends had been identified in the 7 Grievances raised in the year and the number of dignity at work complaints remains very small. Work is underway to review the process for investigating and managing disciplinary cases in the context of the Fair & Just Culture and managers will be trained accordingly to ensure consistency across the Trust.

     The Committee's annual review of Disciplinary/Grievance/Dignity at Work processes and cases, meets the requirements for NHS Board's as set out by NHS Improvement's Chair, Baroness Dido Harding, in her recent letter 'Learning Lessons to improve our People Practices'

following the high profile case involving the death of an NHS employee undergoing a disciplinary process.

- Biannual Safe Staffing Review – The Committee received the biannual Safe Staffing Review and were assured that nurse/midwife staffing levels were safe and appropriate; noting the risk associated with the age profile of the nursing workforce at LWH and the national shortage of nurses and midwives.

- Nursing & Midwifery Strategy Development - An interactive session to inform the development of the refreshed Nursing, Midwifery & AHP Strategy. Committee emphasised the importance of the connectivity between the proposed Strategy and the existing People & Quality Strategies. The draft Strategy will be presented again to PPF Committee in September.

- Policies for approval – Following policies approved:
  - Dignity at Work
  - Supporting Staff Policy
  - Induction Policy
  - Mandatory Training Policy

- Sub Committee Reports – The following sub Committee Reports were received.
  - Diversity & Inclusion – The Committee noted that Workforce Disability Equality Scheme statutory reporting has commenced with submission by 1 August 2019
  - Education Governance – The Committee approved the updated Terms of Reference
  - NHSI Sickness Improvement – The Committee noted the proposed shift in focus of the Group and were concerned that it should not lose sight of its original aim which was to address wider issues impacting on attendance at work rather than the operational performance management of sickness absence, which would be addressed via Divisional performance.
  - Partnership Forum
  - NHSI Retention Group

3. Board Assurance Framework (BAF) risks reviewed
   No new risks identified. No changes to existing risks identified.

4. Escalation report to the Board on Performance Measures
   None.

5. Issues to highlight to Board
   To note the publication of the NHS Interim People Plan and to be assured that the Trust's People Strategy addresses the key issues identified in the NHS interim People Plan; and to note that the Trust has commenced a programme of listening to staff on what would make the NHS the best place to work, as required by the interim People Plan.

   To assure the Board that the annual review of Disciplinary/Grievance/Dignity at Work processes and cases, meets the requirements for NHS Board's as set out by NHS Improvement's Chair, Baroness Dido Harding, in her recent letter 'Learning Lessons to improve our People Practices' issued following the high-profile case involving the death of an NHS employee undergoing a disciplinary process

## 6. Action required by Board

To recommend the Biannual Safe Staffing Review to the Board for approval.

AUTHOR NAME Tony Okotie
DATE 24 June 2019

| Agenda Item | 2019/107 |
|---|---|

| | |
|---|---|
| **MEETING** | **Board of Directors** |
| **PAPER/REPORT TITLE:** | **Annual Report of the Director of Infection Prevention and Control 2018/19** |
| **DATE OF MEETING:** | Thursday, 04 July 2019 |
| **ACTION REQUIRED** | **For Approval** |
| **EXECUTIVE DIRECTOR:** | Caron Lappin, Director of Nursing and Midwifery |
| **AUTHOR(S):** | Tim Neal, Director of Infection, Prevention and Control |
| | |
| **STRATEGIC OBJECTIVES:** | ***Which Objective(s)?***<br>1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒<br>2. To be ambitious and *efficient* and make the best use of available resource ☒<br>3. To deliver *safe* services ☒<br>4. To participate in high quality research and to deliver the most *effective* Outcomes ☒<br>5. To deliver the best possible *experience* for patients and staff ☒ |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | ***Which condition(s)?***<br>***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐<br>***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒<br>***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐<br>***4.*** *Failure to deliver the annual financial plan ……* ☐<br>***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐<br>***6.*** *Ineffective understanding and learning following significant events……* ☐<br>***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒<br>***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ |
| **CQC DOMAIN** | ***Which Domain?***<br>***SAFE-*** *People are protected from abuse and harm* ☐<br>***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐<br>***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐<br>***RESPONSIVE –*** *the services meet people's needs.* ☐<br>***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.*<br>***ALL DOMAINS*** ☒ | | | |
| **LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT** | **1.** Trust Constitution ☒<br>**2.** Operational Plan ☐<br>**3.** NHS Compliance ☒ | | **4.** NHS Constitution ☒<br>**5.** Equality and Diversity ☒<br>***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:-….)*** | ***To approve the*** **Director of Infection, Prevention and Control Annual Report 2018/19** | | | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee name** | | ***Choose an item.***<br>Or type here if not on list:<br>***Click here to enter text.*** | |
| | **Date of meeting** | | ***Click here to enter a date.*** | |
| | | | | |

# Infection Prevention & Control

# Annual Report 2018-2019

## Dr Tim Neal, Director of Infection Prevention & Control

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## TABLE OF ABBREVIATIONS

| | |
|---|---|
| **CCG** | Clinical Commissioning Group |
| **CPE** | Carbapenamase-Producing Enterobacteriaceae |
| **CQC** | Care Quality Commission |
| **DIPC** | Director of Infection Prevention and Control |
| **HCA** | Health Care Act |
| **HCAI** | Health Care Associated Infection |
| **PHE** | Public Health England |
| **IPC** | Infection Prevention & Control |
| **IPCC** | Infection Prevention and Control Committee |
| **IPCN** | Infection Prevention and Control Nurse |
| **IPCT** | Infection Prevention & Control Team |
| **IPS** | Infection Prevention Society |
| **IQR** | Inter-quartile range |
| **LWFT** | Liverpool Women's NHS Foundation Trust |
| **MRSA & MSSA** | Meticillin Resistant (Sensitive) Staphylococcus Aureus |
| **NLMS** | National Learning Management System |
| **NUMIS** | Nursing & Midwifery Information System |
| **OLM** | Oracle Learning Management System |
| **RLBUHT** | Royal Liverpool and Broadgreen University Hospital Trust |
| **SS** | Safety Senate |
| **SSI** | Surgical Site Infection |
| **TVN** | Tissue Viability Nurse |

# 1 Summary of Key Achievements and Main Findings

## 1.1 Key Achievements 2018-19

**The Trust was compliant with the prescribed MRSA bacteraemia target**

**The Trust was compliant with the prescribed C*.difficile* target**

**Table 1: Trust Attributable HCAI**

| Organism | April 2016 - March 2017 | April 2017 - March 2018 | April 2019 - March 2020 |
|---|---|---|---|
| *Clostridium difficile* infection (CDI) | 0 | 0 | 0 |
| Meticillin resistant *Staphylococcus aureus* (MRSA) sepsis | 0 | 0 | 0 |
| Meticillin sensitive *Staphylococcus aureus* (MSSA) sepsis | 0 | 2 | 2 |
| *E.coli* sepsis | 8 | 6 | 7 |

## 1.2 Main Findings

### 1.2.1 Education

The IPCT has maintained current induction and mandatory training.
The IPCT has contributed to local training as required and identified.

### 1.2.2 Guidelines

A Trust wide SOP for cleaning of fans has been created

### 1.2.3 Infection Prevention and Control Audits and Clinical Practice Audits

43 (100%) Infection Prevention and Control Audits, 258 (89%) clinical practice ward audits (including 5 moments for hand hygiene) and 59 community midwives' audits have been completed in accordance with the Trust plan.

### 1.2.4 MRSA

26 adult patients were identified in the Trust with MRSA, 22 were identified by pre-emptive screening. 14 neonates were identified with MRSA colonization.

### 1.2.5 C. difficile

There have been no Trust acquired *C.difficile* infections in 2018-19

### 1.2.6 Bacteraemia

There have been no MRSA bacteraemias reported in 2018-19

There were 3 MSSA bacteraemias in 2018-19 (2 Neonates, 1 Adult)

5 neonates had significant Gram-negative sepsis (3 congenital) and 4 neonates had significant Gram-positive infections (1 congenital).

There were 15 E.*coli* bacteraemias in 2018/19 (4 neonates and 11 adults).

There were no glycopeptide resistant enterococcal bacteremias in 2018-19

### 1.2.7 Surgical Site Infection Surveillance

For the period May 2018 – Mar 2019
1.4% of elective caesarean sections and 2.3% of Emergency Caesarean sections resulted in an SSI.

2.3% of open Gynaecological abdominal surgery and 0.9% of Laparoscopic abdominal surgery resulted in an SSI

## 2 Infection Prevention & Control Team Members

During 2018 - 19 the Infection Prevention and Control team (IPCT) has been supported by a seconded Midwife, and a seconded Neonatal Nurse

**Miss K Boyd**
Infection Prevention & Control Analyst (part time 0.80 WTE - 30 hours/week Infection Prevention and Control Analyst, 0.20 WTE - 7.5 hours/week Policy Officer for the Governance team)
**Mrs D Fahy**
Infection Prevention & Control Nurse - (0.60 WTE – 22.50 hours/week)
**Dr T J Neal**
Consultant Microbiologist – Infection Prevention & Control Doctor and Director of Infection Prevention and Control (DIPC) (2 sessions / week worked on LWFT site)
**Mrs Anne-Marie Roberts**
Seconded Link Midwife (0.40 WTE - 16 hours)
**Mrs Eleanor Walker**
Seconded Link Neonatal Nurse (0.40 WTE – 15 hours)

The IPCT is represented at the following Trust Committees:

| | |
|---|---|
| Safety Senate | Monthly |
| Effectiveness Senate | Monthly |
| Infection Prevention & Control | Bi-Monthly |
| Medicines Management | Bi-Monthly |
| Water Safety Group | Twice yearly |
| Multi Trust Water Safety Group | Monthly |
| PLACE | Ad-hoc |
| Building Planning | Ad-hoc |
| Health and Safety Committee | Quarterly |

The Team is managed by the Deputy Director of Nursing and Midwifery the budget is managed by the IPCN
There are no Trust costs associated with the Infection Prevention and Control doctor and DIPC.

## 3 Role of the Infection Prevention & Control Team

The following roles are undertaken by the IPC team:-

- Education
- Surveillance of hospital infection
    - Surgical Site data collection

    - National bacteraemia data reporting
    - PHE data reporting
- Investigation and control of outbreaks
- Development, implementation and monitoring of Infection Prevention and Control policies
- Audit
- Assessment of new items of equipment
- Assessment and input into service development and buildings / estate works
- Patient care/ incident reviews

Infection Prevention and Control advice is available from the Infection Prevention & Control team and 'on-call' via the DIPC or duty Microbiologist at RLBUHT.

## 4 Infection Prevention and Control Committee

The IPC Committee meets quarterly and is chaired by the Director of Nursing and Midwifery. The committee receives regular reports on Infection Prevention and Control activities from clinical and non-clinical divisions/departments.

Reports received include those from:

- Estates and Operational Services
- Occupational Health
- Decontamination
- Divisions/departments
- Link Group
- Water Safety group
- Infection Prevention and Control team members

The Terms of Reference of the IPCC are included as **Appendix A**

The IPCT report quarterly to IPCC and the DIPC reports quarterly to Safety Senate (SS) which also receive minutes of the IPCC meetings. The Quality committee (QC) receives minutes from SS. The Trust Board also receives an annual presentation and report from the DIPC.

Trust IPC issues, processes and surveillance data are relayed to the public via Infection Prevention and Control posters, patient information leaflets, the Trust website (copy of this report) a notice board in the main reception which is updated on a monthly basis and departmental notice boards in ward areas.

Throughout the year many changes in practice have been initiated, facilitated, supported or mandated through the work of the IPCT and IPCC. Some of these are on a large scale, such as input of the IPCT into large capital projects undertaken by the Trust (see section 8.2) however many appear smaller and take place in the clinical areas as a consequence of audit, observations and recommendations. These interventions equally contribute to the provision of clean and safe care in the organisation. The IPCT examined its effectiveness throughout the year. The following detail some of the changes facilitated throughout the year.

- The IPCT have identified that ANTT training is required more frequently this has been agreed at IPCC.

- IPCT more visible within areas

## 5 External Bodies

### 5.1 Health Care Act & Care Quality Commission

The Health Care Act (HCA) was published in October 2006 and revised in January 2008 and January 2011 as the Health and Social Care Act. This code of practice sets out the criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment where the risk of HCAI is kept as low as possible.

The Health Care Act action plan is a standing item on the IPCC agenda which monitors progress. There is one outstanding standard of the HCA with which the Trust is not fully compliant; (detailed in Appendix B). This relates to surveillance software which is awaiting the implementation of suitable software at the provider laboratory with hope of acquisition by LWFT following this.

### 5.2 Liverpool Clinical Commissioning Group (CCG) Assurance Framework

Assurance data is reported monthly to the CCG and bi-monthly at IPCC it incorporates performance data, exception reporting audit data and screening compliance.

### 5.3 Mandatory Surveillance

The Trust submits data on MRSA, MSSA, *E.coli, Clostridium difficile, Klebsiella* and *Pseudomonas* infections by the 15$^{th}$ day of each month to the Public Health England via an online Health Care Associated Infection Data Capture System. HCAI data is also submitted each month for the Trust Quality Report and Corporate Information.

## 6 Education

### 6.1 Mandatory training and Induction:

Mandatory training in Infection Prevention and Control is a requirement for all Trust staff including clinical, non-clinical staff and contractors. The IPCT update the training package annually and ensure that it reflects best practice, national recommendations and issues identified as non-compliant in the previous year. All staff receives training in Infection Prevention and Control every three years via electronic learning and a Hand Hygiene Assessment. The electronic package is incorporated into the NLMS and linked to OLM. Ten hand hygiene sessions have been delivered on corporate induction throughout 2018-19

Training continues to be provided by the IPCT for medical staff which includes consultants, trainees and ad-hoc mandatory training for corporate services. Five formal teaching sessions have been delivered by the DIPC throughout 2018-19

The IPCT has provided 23 general training sessions in 2018-19 (Including, the use of standard precautions, and Audit/NUMIS training)

Although the majority of mandatory training is delivered by the IPC team a number of Link Staff also provide training including hand hygiene within their areas.

### 6.2 Link Staff

The IP&C link staff meetings have changed to twice yearly and held at the end of the Professional Development days. The programme is organised to reflect current initiatives, implementation of new guidance and reinforcement of any non-compliance relating to IPC.

The number of attendees on each development day was 10 (50%) and 7 (35%), Link Staff meetings and Professional Development days are included in the TNA provision for Link Staff.

### 6.3 ANTT Training

ANTT is included in the training days provided by each division however records are not yet available by OLM. The IPCT have liaised with Training Department and this information should be readily available from June 2019. 13 sessions were provided by the IPC team in 2018-19.

### 6.4 Guidelines/Policies

No new IPC policies have been required. The existing IPC policy and SOP's have been reviewed in line with Trust policy

- Cleaning of Fans SOP created

## 7 Audits

### 7.1 ICNA Trust audit programme

The IPCT continue to use the IPS audit tools originally devised in 2004. The audit programme for the year is established and agreed by the IPCC. Clinical practice audits (PPE, and Hand Hygiene) are completed with a minimum frequency of twice yearly by ward/clinical staff. 5 moments for hand hygiene audits are completed by ward/clinical staff monthly.

The IPS Clinical Practice audits, Saving Lives audits and monthly '5 moment's' audits are entered onto the NUMIS system allowing real-time oversight of results and compliance by local managers. A total of 65 (83.5%) Clinical Practice audits have been carried out by ward department staff and have been reviewed by the IPCT. Clinical Practice audit scores range from 93-100% with a mean score of 99%. A total of 193 (89%) Hand Hygiene audits have been carried out by ward department staff and have been reviewed by the IPCT. Hand Hygiene audit scores range from 90-100% with a mean of 99%.
A common theme of non-compliance with documentation on the VIAAD chart has been identified within Saving Lives Ongoing Cannula care audits. The IPCT have given feedback to relevant departments and local action plans have been implemented.

The IPS Environmental, Ward, Kitchen, Linen and Waste audits have been streamlined into an overarching Infection Prevention and Control Audit. The Infection Prevention and Control audits are carried out twice a year in each clinical area unannounced by the IP&C team. A total of 43 Infection Prevention and Control audits (reviewing the general environment and clinical practice) in 21 clinical areas have been undertaken. Individual department scores, main themes of non-compliance and areas of improvement are recorded and available on NUMIS - and emailed to Matrons and Ward Mangers.

2018 - 2019 IPC audit scores range from 83-100% with a mean score of 95%

Community midwives are expected to complete a combined self- assessment of environmental and clinical practice elements twice per year. The Community Team Leaders are responsible for entering the data. From the period April 2018-March 2019 54 self-assessments have been completed.

There have been insufficiencies with the NUMIS system in relation to entering and viewing ward scores. The IPCT are aware and have been involved in the re-implementation of NUMIS. A temporary excel database has been utilised to collate audit data. The completion date for the updated NUMIS system is April 2019. This is scheduled to go live in all areas in June 2019.

### 7.2 Mattress audits

Mattress audits are completed in all areas in the Trust. The audit examines cleanliness and mattress integrity. Results are reported through the Divisional report to IPCC. The audits are forwarded to IP&C team but local areas have ownership for replacement and condemning of any mattress not fit for purpose. There is a system in place for the provision and storage of replacement mattresses across the Trust.

## 8 Other Issues

### 8.1 Water Safety

The Water Safety group has met in line with its terms of reference. The Trust has an appointed Authorising Engineer (water) to support the Water Safety group. The Trust Executive Management group has agreed that the Trust participate in a Multi-Trust Water Safety group which includes representatives of 4 neighbouring Trusts and allows standardisation of policies and procedures involving safe water practices. The Multi-Trust Water Safety group is reviewing a common Water Safety plan. Water testing for *Pseudomonas aeruginosa* in augmented care areas has been performed in accordance with national guidance and results have been compliant with expected standards.

### 8.2 Building Projects & Design Developments

The team remain reliant on the Estates department and the Divisions alerting and involving the team in impending projects via the Infection Prevention and Control committee meetings.

2018 - 19 projects requiring IPC Team involvement included:

- Neonatal Unit redevelopment
- Reopening of Jeffcoate Ward
- Maternity Base reception Area

## 9 Surveillance of Infection

Hospital infection (or possible infection) is monitored in the majority of the hospital by 'Alert Organism Surveillance' this involves scrutiny of laboratory reports for organisms associated with a cross infection risk e.g. MRSA, *Clostridium difficile* etc.

On the Neonatal Unit, which houses most of the long-stay patients, surveillance is undertaken by both ‘Alert Organism’ and by prospective routine weekly surveillance of designated samples. The IPCT examines results of these samples and action points are in place for the unit based on these results.

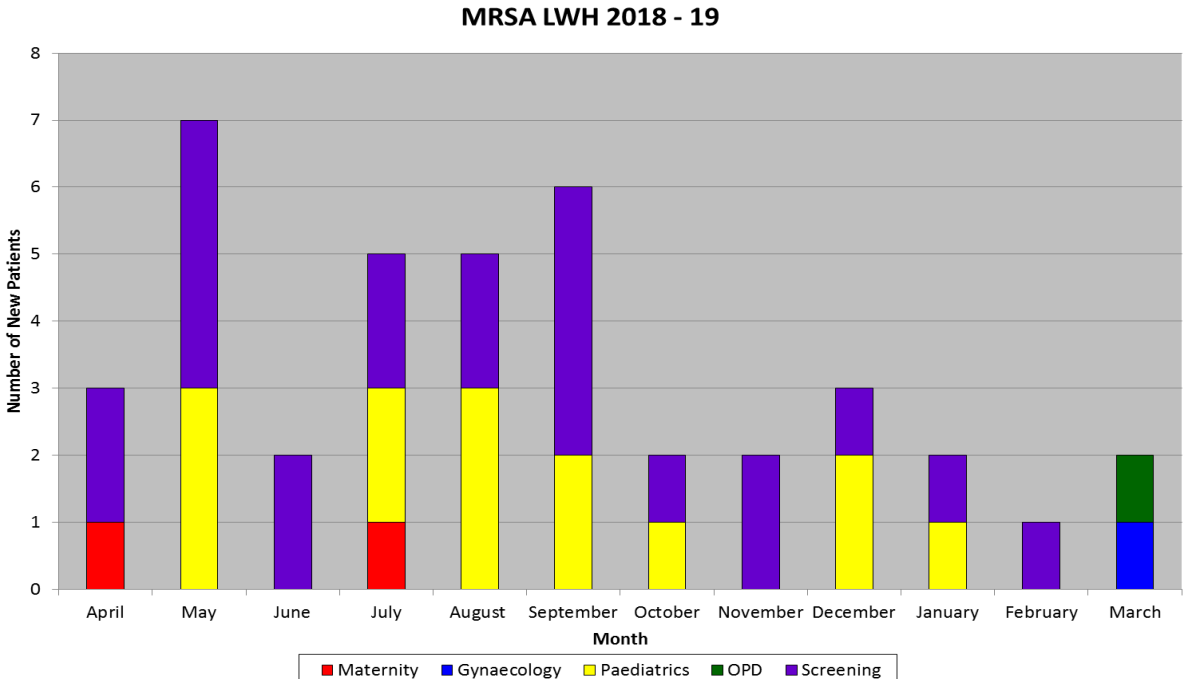
Surveillance of bacteraemias (blood stream infections) for both national mandatory and in house schemes is also undertaken. National mandatory reporting of blood stream infections includes *Klebsiella* and *Pseudomonas* in addition to *E.coli* and *S.aureus.*

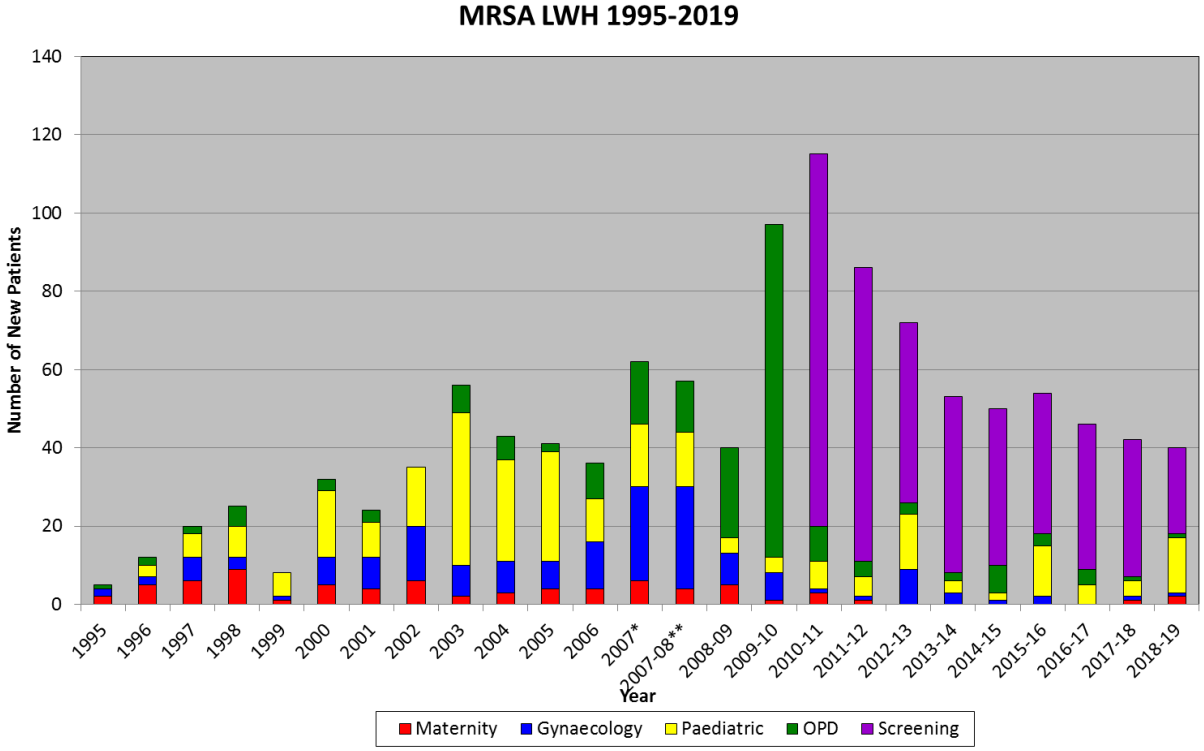
The surveillance system for surgical site infections by the IPCT was suspended in November 2017 as staffing levels in the IPCT were depleted. Surgical Site Surveillance recommenced 1st May 2018

## 9.1 Alert Organism Surveillance

### 9.1.1 MRSA

The total number of patients identified carrying Methicillin Resistant *Staphylococcus aureus* (MRSA) in the Trust during the year 2018-19 was 40. The majority of patients were identified by routine screening either on or prior to admission. In the reporting year there was an increased proportion of neonates identified with MRSA colonisation. The charts below show the number of new patients identified with MRSA and the annual totals for the period 1995 – 2019.



As outlined in previous Annual Reports the Government had established targets for screening such that all elective admissions and all eligible emergency admissions to hospital should be screened for carriage of MRSA.

In the period April 2018 to March 2019 4035 adult patients were screened for MRSA carriage; 24 (0.5%) were positive.

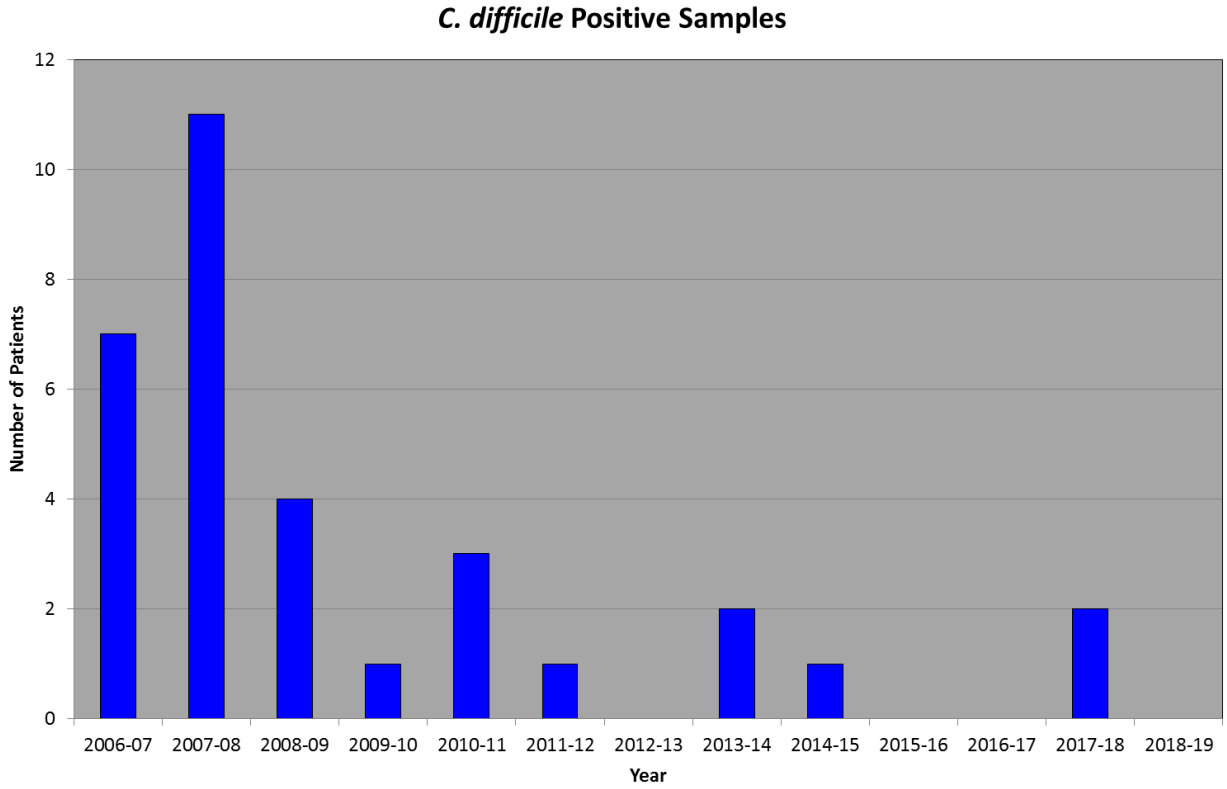
One patient was identified with an MRSA superficial skin infection following discharge from the Trust.

During the period of this report 14 babies were identified with MRSA There was a cluster of neonatal cases during the summer period of 2018, the same strain was identified in other regional neonatal units. The cluster was investigated but no specific mechanism of transmission was identified. There were no clusters or other epidemiological linking of adult patients with MRSA.

There were no MRSA bacteraemias in adult or neonatal patients in the reported year.

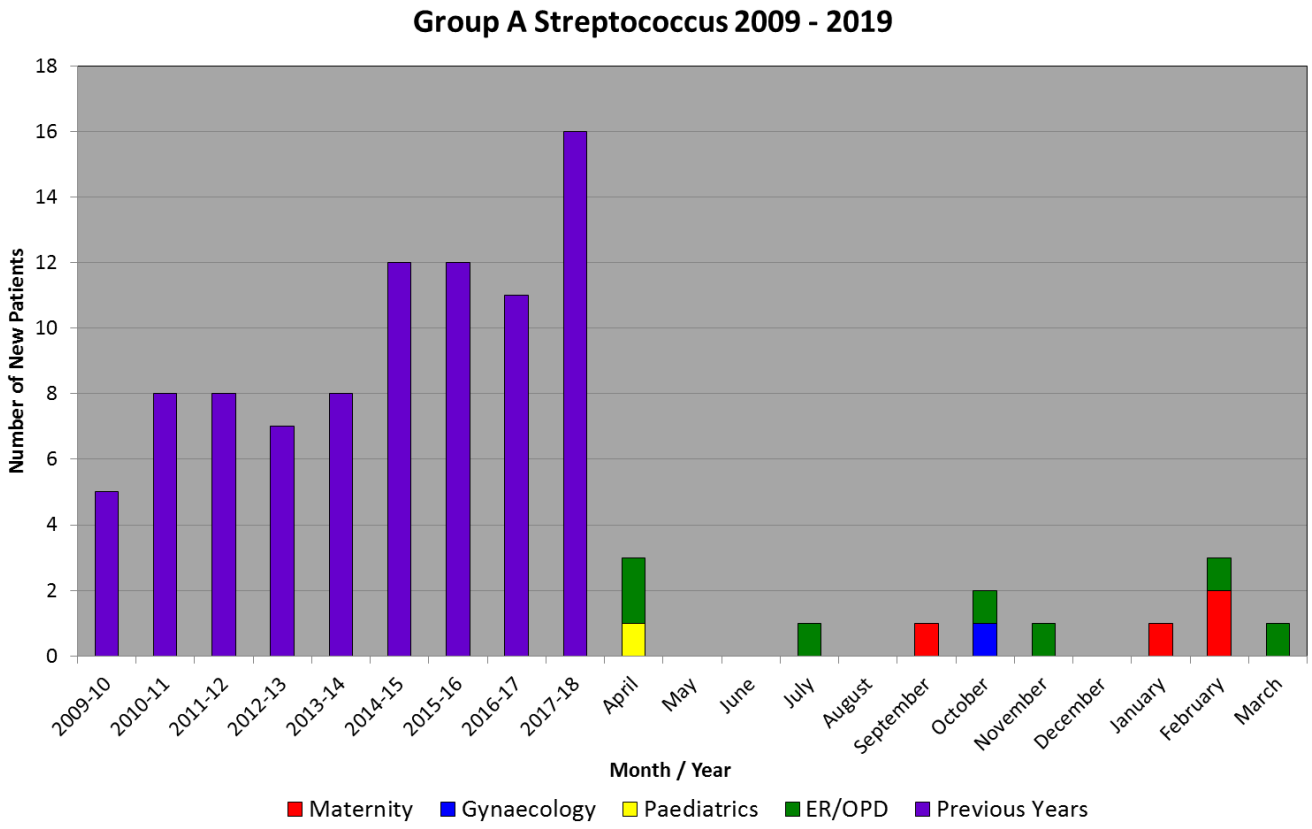
### 9.1.2 Clostridium difficile

Mandatory reporting of this disease commenced in January 2004 and includes all patients over 2 years old. Historically the number of cases at LWFT has been low (see chart below). The prescribed trajectory for this disease for the Trust in 2018-19 was one.
During the period April 2018 to March 2019 there were no patients identified with *C.difficile* infection in the Trust.



### 9.1.3 Group A Streptococcus

In the period April 2018 to March 2019, 13 patients were identified with Group A Streptococcus as detailed below. In addition a patient who had been an in-patient in the Trust was admitted shortly after discharge to a neighbouring Trust with invasive Group A Streptococcal infection (iGAS). All patients with Group A Streptococcal infection are reviewed. There was no identified transmission of Group A Streptococci in the Trust.




### 9.1.4 Glycopeptide Resistant Enterococcus (GRE)

There were no GRE bacteraemia's reported.

### 9.1.5 Carbapenemase Producing Enterobacteriaceae

The screening for multidrug - resistant organisms was incorporated into National guidance and in 2014 LWH commenced screening patients in high risk groups for Carbapenemase producing Enterobacteriaceae (CPE). In June 2016 the screening process was extended. All patients who have been an inpatient in any other hospital within the preceding 12 months require screening. Meditech facilitates the risk assessment. CPE screening compliance is audited weekly by the IPCT Overall compliance –83%.

| Month | Screening Compliance |
|---|---|
| **Apr 18 - June 18** | 79% |
| **July 18 – Sept 18** | 85% |
| **Oct 18 – Dec 18** | 83% |
| **Jan 19 – Mar 19** | 86% |

The main theme of non-compliance identified has been missed screens on patients who are direct transfers from another hospital. This issue has been addressed with Ward Managers, IPCT Link staff and clinical staff in the relevant areas.

### 9.1.6 Routine Neonatal Surveillance

Nearly all infection on the Neonatal unit is, by definition, hospital acquired although a small proportion is maternally derived. Routine weekly colonization surveillance has continued this year on the Neonatal unit. Results are shown in Appendix C

As colonisation is a precursor to invasive infection the purpose of this form of surveillance is to give an early warning of the presence of resistant or aggressive organisms and to ensure current empirical antimicrobial therapy remains appropriate. Action points are embedded in the Neonatal unit and IPC policies linked to thresholds of colonisation numbers to limit spread of resistant or difficult to treat organisms.
As well as resistant or aggressive organisms focus has remained on both *Pseudomonas spp*. and *Staphylococcus aureus* as potential serious pathogens. The median number of babies colonized with *Pseudomonas* each week was 1 (unchanged from the previous year), and with *S.aureus* was 3 (reduced from 5).

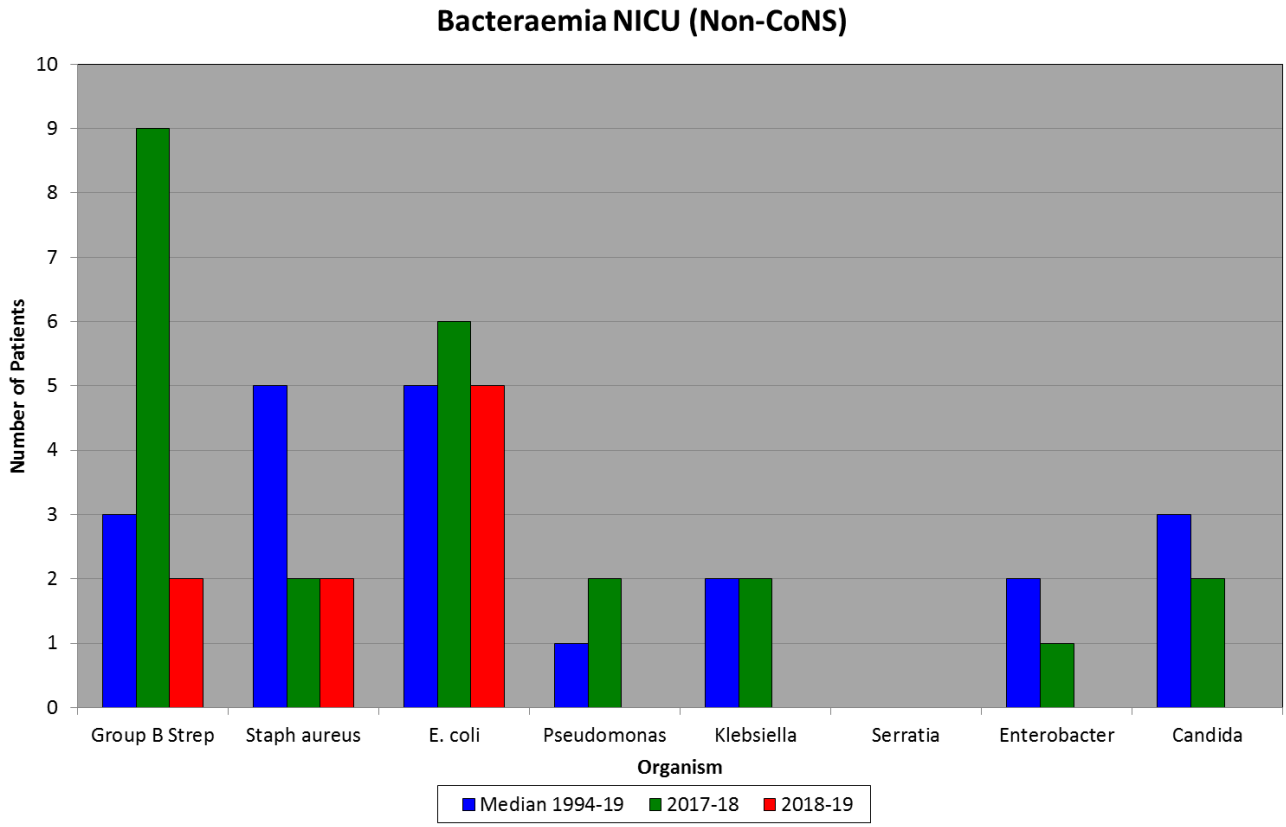
## 9.2 Bacteraemia Surveillance

### 9.2.1 Neonatal Bacteraemia

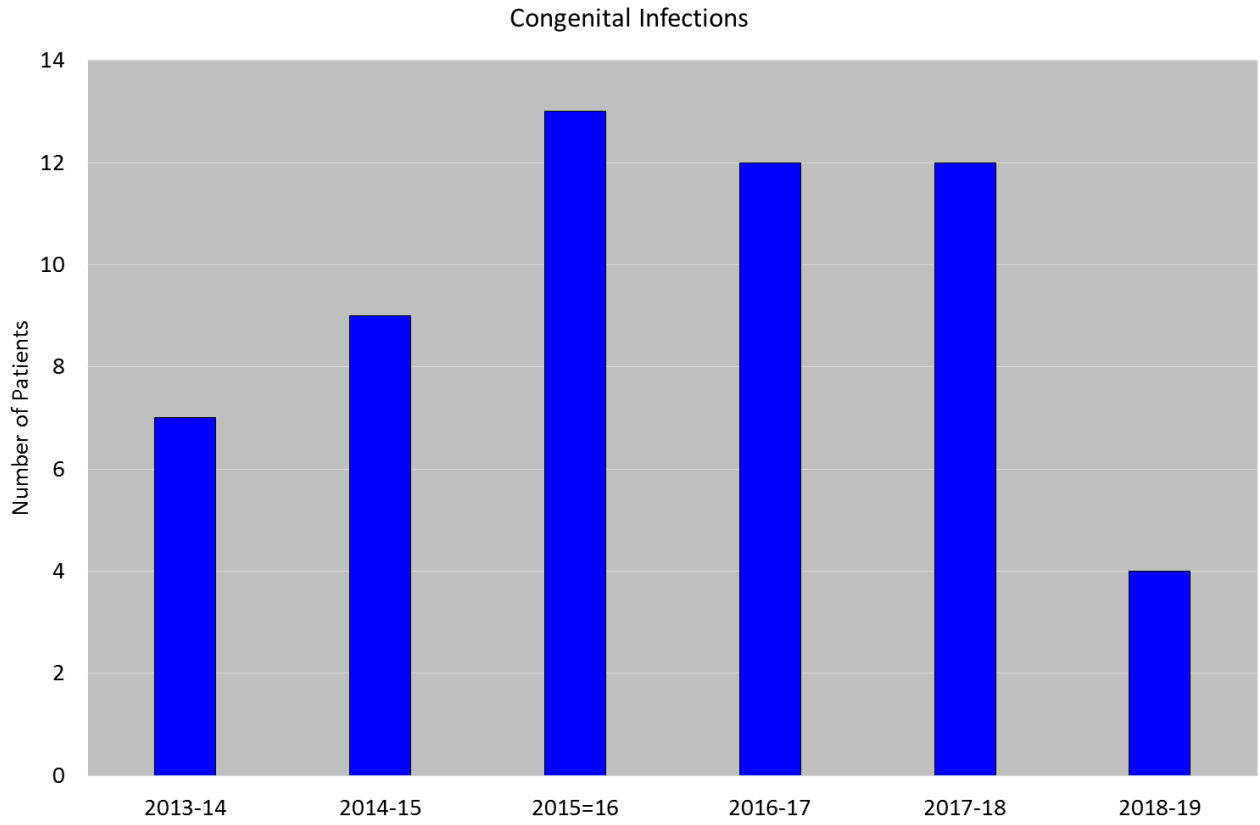
As always the commonest organism responsible for Neonatal sepsis was the common skin organism, coagulase-negative staphylococcus (CoNS). In the period April 2018 – March 2019 5 babies (14 in 2017-18 and 14 in 2016-17) had infections with Gram-negative organisms, 3 of these infections (all *E.coli*) occurred in the first 5 days of life and were congenitally acquired. The remaining 2 *E.coli* infections occurred in the same baby and presented after 5 days of life.

There were 4 episodes of infection with significant Gram-positive pathogens (12 in 2017-18); 2 cases were Group B streptococcus (1 congenital and 1 late onset) the other 2 were both late onset *S.aureus* infections.

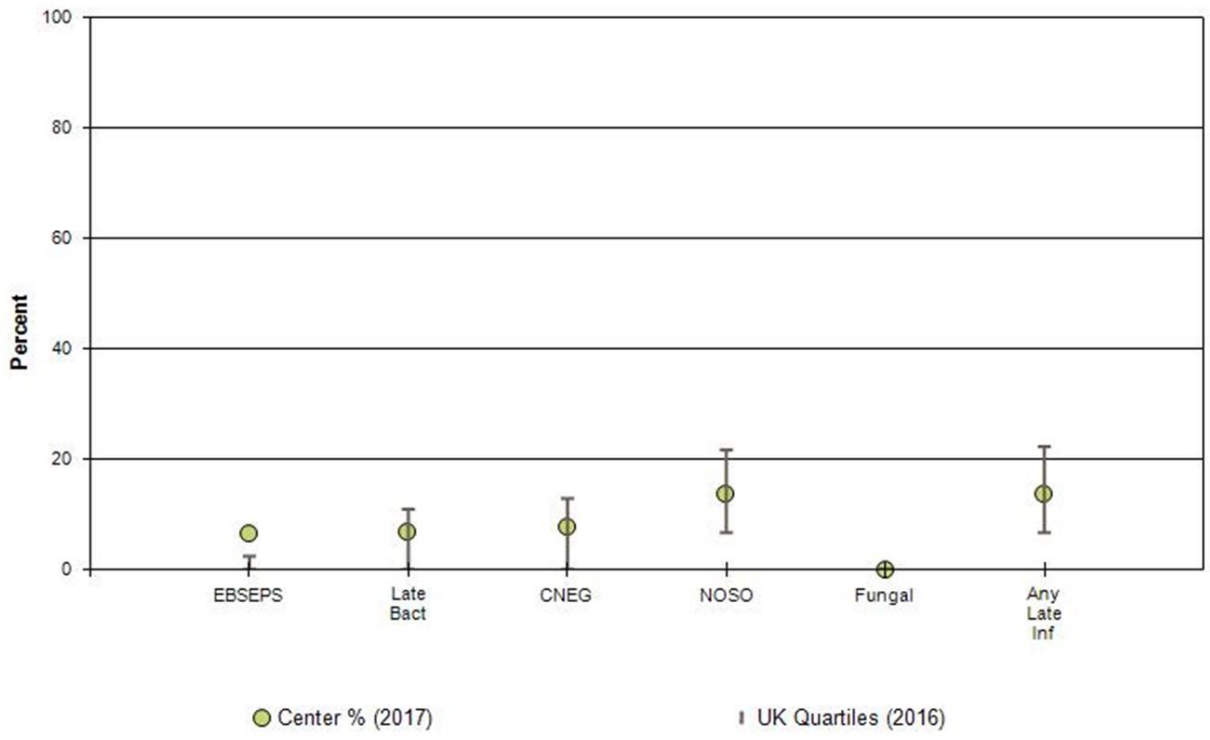
All Non-coagulase-negative Staphylococcal sepsis on the unit is subject to a review to determine the focus of infection, precipitating causes and the appropriateness of care.
The bar chart below describes the pattern of ‘definite-pathogen’ Neonatal bacteraemia in the current year in comparison to last year and the median value for each organism for preceding years. There is considerable variability in the figures from year to year (probably reflecting the complex of pathogen host relationship in this group).




As outlined in last year's report the IPCT have been monitoring the number of Neonatal infections classified as 'congenital'. 4 babies this year had congenital infection.



The Neonatal Unit continues to monitor standardised infection rates. The most recent data (2017) show overall rates of bloodstream infection are within the IQR. As reported in last year's annual report the Early Onset Sepsis (EBSEPS) was high last year although that increase has not been evident in the current reporting year.

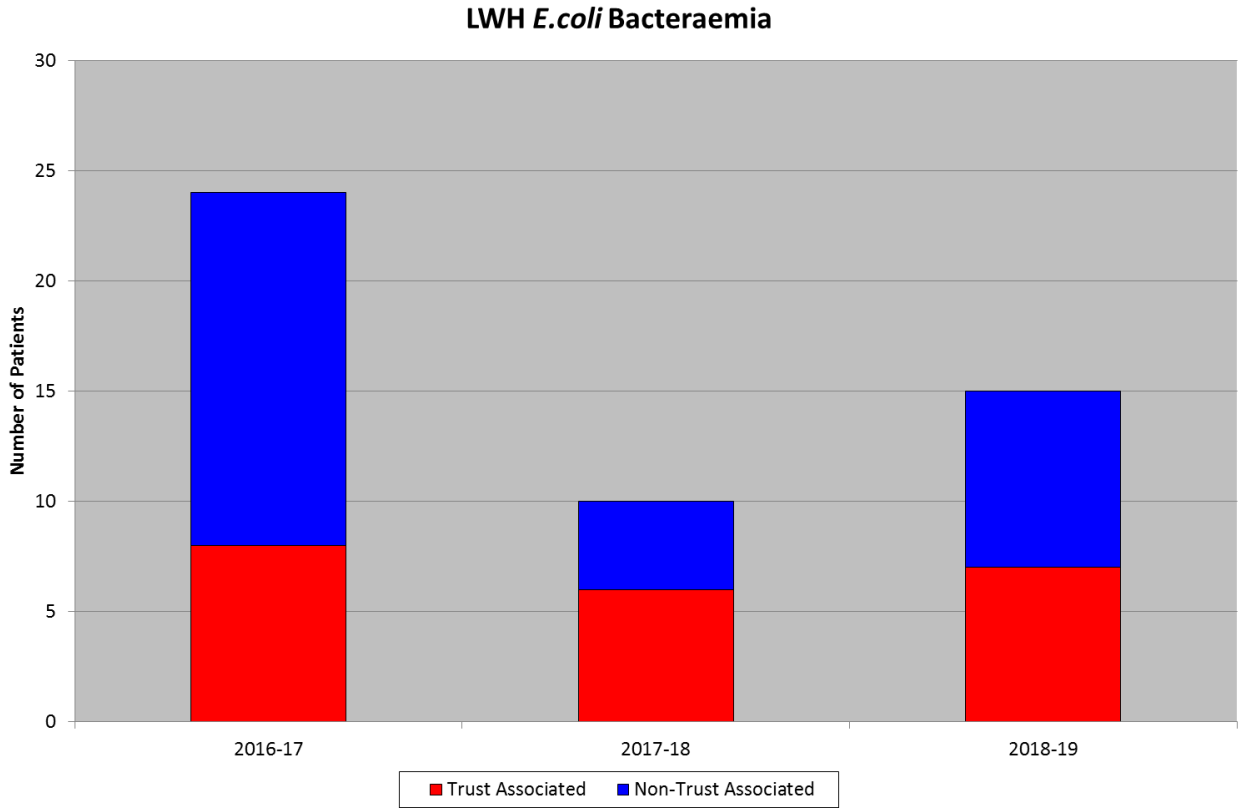



### 9.2.2 Mandatory Bacteraemia Surveillance

There have been no MRSA bacteraemia cases in adult or neonatal patients in the period April 2018 to March 2019, however 2 neonates developed MSSA bacteraemia (see section 11.1) and 1 adult presented to the Trust with community onset MSSA bacteraemia.

The CCG has a prescribed target to reduce *E.coli* bacteraemia by 10% in 2018-19. Although this was not a specific Trust target the IPCT have been working with regional groups facilitated by the CCG to reduce *E.coli* sepsis. In 2018-19 the Trust reported 15 *E.coli* bacteraemias (5 Neonates (3 congenital) and 10 adults). A reduction in *E.coli* sepsis has not been demonstrated in year. One Klebsiella and one Pseudomonas sepsis were reported in 2018-19.

The IPCT expect clinical areas to undertake an RCA of all significant bacteraemias to establish any elements of sub-optimal care. A regular multidisciplinary meeting is held with members of the maternity division to review all infective pathology. As a consequence of these meetings the process of managing antenatal bacteriuria has been strengthened. The use of vacuum assisted wound dressings and pre-op vaginal cleansing has also been introduced.




In addition to the mandatory surveillance the IPCT has been collecting clinical data on bacteraemic adults in the Trust; 32 patients were identified with positive blood cultures from 345 cultures submitted (10%). 12 (36% of positives, 4% of total) of these were contaminated with skin organisms. Details of the 20 significant bacteraemias are provided in Appendix D

### 9.3 Surgical Site Surveillance

Surgical Site Infection (SSI) is one of the most common healthcare associated infections, estimated to account for 15% of HCAI. National surveillance for abdominal hysterectomy suggests an SSI incidence of 1.5%. There is no national data for caesarean sections however studies report rates between 2% & 20% with the highest incidence being in emergency sections.

Surgical Site wound surveillance in both Maternity and Gynaecology was re-established in 2014 - 15 to include all abdominal procedures and groin node dissections. In April 2016 wound surveillance extended to include perineal surgical site infections. Data has been collected by a member of the IPCT using a standard surveillance sheet. Surveillance includes the inpatient period for all patients and the post discharge period until the 30th day.

As a number of wound infections are diagnosed post discharge, the numbers actually seen by the IPCT are limited at the inpatient period. Some patients who develop infection post discharge will be captured via community notes (although these often take several weeks to return to the Trust) and patients who represent to the Trust. A more formal process of post-discharge surveillance has been established including additional information on Meditech for Maternity Assessment unit post-natal attendees and for Community Midwife patient discharges.

### 9.3.1 Maternity

Wound infections are assigned by the time of operation rather than the time infection is recognised i.e. an infection identified in November from surgery in October will be recorded in October's figures. Potential Surgical Site Infections are discussed at a monthly review meeting.

In the month period (May 2018 – March 2019) 2250 Caesarean Sections were undertaken (1099 elective, 1151 emergency). 42 patients fulfilled the criteria for SSI. 15 were in elective and 27 in emergency cases (1.4% and 2.3% respectively).

### 9.3.2 Gynaecology

1820 abdominal procedures were undertaken in the 11 month period in Gynaecology / Gynaecology-oncology with 351 procedures being open and 1469 being laparoscopic. 21 patients fulfilled the criteria for SSI, 8 in open and 13 in the laparoscopic category (2.3% and 0.9%respectively).

## 10 Risk Register

- 1578 - Risk of infectious diseases causing disruption to Trust services including risk to patient and staff safety requiring the implementation of emergency preparedness intervention

## 11 Health & Wellbeing

The Trust Health & Wellbeing Department report monthly to the IPCC including vaccination updates. Staff have historically been screened for TB, Hepatitis B and Rubella immunity. Guidance on Measles, Chicken pox, HIV and Hepatitis C have been incorporated for all 'new starters' and a catch up exercise is in place for staff already employed. The IPCC supports the Health & Wellbeing team in ensuring that workers in designated areas have appropriate vaccinations and immunity.

## 12 Infection Control Team Work Plan

### 12.1 Infection Control Team Work Plan 2018-19

| Work Plan | Completion Date | Comments |
|---|---|---|
| **Training** | | |
| • Continue all Trust mandatory & induction training | Ongoing | |
| • Continue to support link staff personal development | | |
| **Audit** | | |
| • Review ~~ICNA~~/IPS Audit Programme in line with other local Trusts | May 2018 | Standardised audit tool introduced |
| • Continue Saving Lives audits including cannulation | October 2018 | Responsibility transferred to wards |
| • Continue monitoring of pool cleaning | October 2018 | Responsibility transferred to wards |
| **Surveillance** | | |
| • Continue 'Alert Organism' surveillance focused on resistant pathogens | Ongoing | |
| • Continue to monitor cases mandatorily reportable infections | | |
| • Undertake a comprehensive review surgical site infections where figures indicate a rising incidence | | Commenced May 2018 |
| • Implement actions identified through RCA of bacteremia's and C.difficile infections | April 2018 | Regular meetings with Maternity established to discuss all infections |
| • Work with the CCG and Trust Sepsis lead to deliver their target reduction in Gram-negative sepsis. | | DIPC attends meetings with CCG on behalf of the Trust |
| **Health Act & NICE** | | |
| • Review compliance and evidence | Ongoing | |
| • Review and ensure Trust maintains its compliance with current NICE guidance relating to infection, infection control, sepsis and antimicrobial stewardship. | | |

## 12.2 Infection Control Team Work Plan 2019-20

| Work Plan | Completion Date | Comments |
|---|---|---|
| **Training**<br>• Continue all Trust mandatory & induction training<br>• Continue to support link staff personal development | | |
| **Audit**<br>• | | |
| **Surveillance**<br>• Continue 'Alert Organism' surveillance focused on resistant pathogens<br>• Continue to monitor cases mandatorily reportable infections<br>• Undertake a comprehensive review surgical site infections<br>• Implement actions identified through RCA of bacteremia's and C.difficile infections<br>• Work with the CCG and Trust Sepsis lead to deliver their target reduction in Gram-negative sepsis. | | |
| **Health Act & NICE**<br>• Review compliance and evidence<br>• Review and ensure Trust maintains its compliance with current NICE guidance relating to infection, infection control, sepsis and antimicrobial stewardship. | | |

## 13 Appendices

### 13.1 Appendix A – Terms of Reference - Infection Prevention and Control Committee Terms

# INFECTION PREVENTION AND CONTROL COMMITTEE TERMS OF REFERENCE

| | |
|---|---|
| **Constitution:** | The Committee is established by the Trust Board and will be known as the Infection Prevention and Control Committee. |
| **Duties:** | The Committee is responsible for providing assurance to the Trust Board in relation to those systems and processes it monitors and ensure compliance with external agency's standards e.g.: CQC etc.<br><br>1. Agree and disseminate the systems and processes for effective Infection Prevention and Control.<br><br>2. Develop the strategic direction of Infection Prevention and Control, ensuring that the team is resourced sufficiently to achieve improvement in performance.<br><br>3. Review and approve the work of the Infection Prevention & Control team members in line with Trust objectives through the IPCC team work plan.<br><br>4. Review and endorse all policies relating to Infection Prevention & Control and evaluate their implementation.<br><br>5. Receive and review regular reports of infection incidents or outbreaks and ensure that reports are forwarded to appropriate external authorities.<br><br>6. Ensure that lessons identified from incidents, outbreaks, or reports from external organisations are actioned by relevant Divisions in the organisation.<br><br>7. Implement a regular reporting timetable including comprehensive Division reports and reports from support services at regular intervals.<br><br>8. Ensure that effective Infection Prevention and Control is being delivered in Divisions and monitor evidence of prevention and control practice.<br><br>9. Promote and facilitate the education of staff of all grades in hand hygiene Infection Prevention & Control and related topics<br><br>Receive, discuss and endorse the annual Infection Prevention & Control report produced by the Infection Prevention & Control team prior to submission to the Safety Senate Committee and Trust Chief Executive. |

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| **Membership:** | The Committee membership will consist of:<br><br>• The Chair – Director of Nursing, Midwifery or Representative of CEO<br>• Director of Infection Prevention and Control<br>• Trust Decontamination Lead<br>• Infection Prevention & Control Nurse<br>• Family Health Safety Lead<br>• Gynaecology Safety Lead<br>• Clinical Support Services Safety Lead<br>• Occupational Health Nurse<br>• Matron from Gynaecology<br>• Matron from Family Health (Maternity)<br>• Matron from Family Health (Neonatal)<br>• Matron from Gynaecology (Reproductive Medicine Unit)<br>• Matron from Clinical Support Services<br>• Antibiotic Pharmacist<br>• Estates or Patient Facilities Manager<br>• Health and Safety Advisor<br>• Representative from Clinical Commissioning Group<br>• Representative of Public Health England<br><br>Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum<br><br>The Committee will appoint a member of the Committee as Chair of the Infection Prevention and Control committee and another member to be Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent. |
| **Quorum:** | Chair (or approved Deputy)<br>DIPC or IPCN<br>Representative from each Division (either Safety Lead or Matron)<br>Representative from Facilities Department |
| **Voting:** | Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority? |
| **Attendance:** | **a. Members**<br>Members will be required to attend a minimum of 75% of all meetings.<br>Safety Leads and external representatives will be required to attend a minimum of 50% of all meetings.<br><br>**b. Officers**<br>The DIPC / Director of Nursing, Midwifery shall normally attend meetings.<br><br>Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of |

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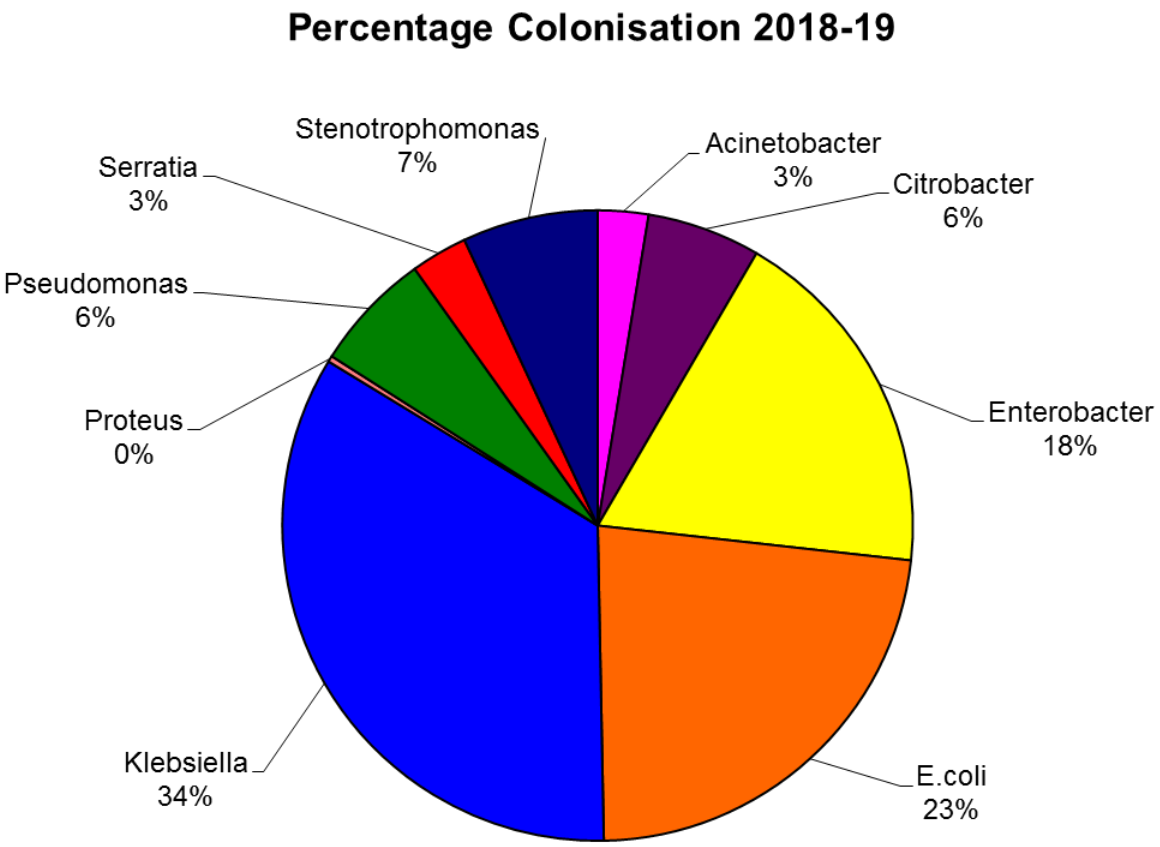
| | operation or responsibility is being discussed.<br><br>Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights. |
| **Frequency:** | Meetings shall be held 4 times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust. |
| **Authority:** | The Committee is authorised by the Trust to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee |
| **Accountability and reporting arrangements:** | The Committee will be accountable to the Chief Executive and Trust Board. The minutes of the committee will be formally recorded and submitted to the Quality committee (QC). The Chair of the committee shall draw to the attention of the QC any issues that require disclosure to it, or require executive action.<br><br>The committee will report to the Board annually on its work and performance in the preceding year.<br><br>Trust standing orders and standing financial instructions apply to the operation of the Infection Prevention and Control committee. |
| **Monitoring effectiveness:** | The Infection Prevention and Control committee / IPC team will undertake an annual review of its performance against its duties in order to evaluate its achievements. |
| **Review:** | These terms of reference will be reviewed at least annually by the Infection Prevention and Control committee. |
| | |
| **Reviewed by [Committee/ Subcommittee/Group]:** | Infection Prevention and Control committee |
| **Approved by [name of establishing Committee]:** | Infection Prevention and Control committee |
| **Review date:** | April 2019 |
| **Document owner:** | Caron Lappin, Director of Nursing and Midwifery<br>Caron.lappin@lwh.nhs.uk |

## 13.2 Appendix B – Health Care Act

| Criterion | Additional Quality Elements | Baseline Assurance October 2018 | Update January 2019 | Responsibility | RAG |
|---|---|---|---|---|---|
| 1.8 An infection prevention and control infrastructure should encompass:<br>In acute healthcare settings for example, an ICT consisting of appropriate mix of both nursing and consultant medical expertise (with specialist training in infection control) and appropriate administrative and analytical support, including adequate information technology. The DIPC is a key member of the ICT | | Awaiting implementation at Host Laboratory site prior to implementation at LWFT | Awaiting implementation at Host Laboratory site prior to implementation at LWFT | Director of Nursing / Midwifery / Director of Infection Prevention and Control | Amber |

### 13.3 Appendix C - Neonatal Colonisation Surveillance

| Organism | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012-13 | 2013/14 | 2014/15 | 2015-16 | 2016-17 | 2017-18 | 2018-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Acinetobacter | 1 | 1 | 2 | 1 | 3 | 3 | 6 | 3 | 3 | 3 | 3 |
| Citrobacter | 2 | 4 | 2 | 6 | 6 | 4 | 3 | 4 | 7 | 4 | 6 |
| Enterobacter | 12 | 16 | 15 | 21 | 21 | 17 | 14 | 17 | 22 | 19 | 18 |
| E.coli | 29 | 30 | 30 | 23 | 20 | 30 | 27 | 21 | 22 | 28 | 23 |
| Klebsiella | 32 | 33 | 31 | 38 | 32 | 34 | 39 | 41 | 35 | 31 | 34 |
| Proteus | 3 | 2 | 4 | 0 | 3 | 1 | 1 | 1 | 1 | 1 | 0 |
| Pseudomonas | 18 | 10 | 9 | 6 | 11 | 5 | 4 | 3 | 3 | 4 | 6 |
| Serratia | 1 | 3 | 4 | 2 | 2 | 2 | 1 | 3 | 2 | 5 | 3 |
| Stenotrophomonas | 2 | 1 | 3 | 3 | 2 | 4 | 4 | 7 | 5 | 5 | 7 |



### 13.4 Appendix D - Adult Bacteraemia Surveillance 2018 - 19

32 Positive blood cultures

12 Coagulase-negative staphylococcus or other contaminant.

20 Pathogens

| Directorate | Organism | Potentially Hospital Associated | Likely Source |
|---|---|---|---|
| **Gynaecology** | *Klebsiella spp* | Y | Urine |
| | *S.anginosus* | Y | Pelvis |
| | *E.coli* | N | Pelvis |
| | *E.coli* | N | UTI |
| | *P.aeruginosa* | N | Pelvis |
| | | | |
| **Maternity** | *E.coli* | N | UTI |
| | *E.coli* | N | UTI |
| | *E.coli* | N | RPOC |
| | *E.coli* | N | UTI |
| | *E.coli* | Y | Endometritis |
| | *E.coli* | N | Endometritis |
| | *E.coli* | N | UTI |
| | *E.coli* | N | Endometritis |
| | *H. parainfluenzae* | N | Chorioamnionitis |
| | *Listeria monocytogenes* | N | Sepsis |
| | *S.aureus* | N | Non-identified |
| | *P.mirabilis* | N | Endometritis |
| | *Prevotella spp* | N | Pelvis |
| | Group B Streptococcus | N | Peripartum |
| | *Veillonella spp* | N | Chorioamnionitis |

| Agenda Item | 2019/109 |
|---|---|

| | |
|---|---|
| MEETING | Board of Directors |
| PAPER/REPORT TITLE: | Better Births compliance – Community Midwifery Update |
| DATE OF MEETING: | Thursday, 27 June 2019 |
| ACTION REQUIRED | For Assurance |
| EXECUTIVE DIRECTOR: | Caron Lappin, Director of Nursing and Midwifery |
| AUTHOR(S): | Sue Roberts Matron |
| | |
| STRATEGIC OBJECTIVES: | *Which Objective(s)?*<br>1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒<br>2. To be ambitious and *efficient* and make the best use of available resource ☒<br>3. To deliver *safe* services ☒<br>4. To participate in high quality research and to deliver the most *effective* Outcomes ☒<br>5. To deliver the best possible *experience* for patients and staff ☒ |
| LINK TO BOARD ASSURANCE FRAMEWORK (BAF): | *Which condition(s)?*<br>*1. Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒<br>*2. Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐<br>*3. The Trust is not financially sustainable beyond the current financial year……* ☐<br>*4. Failure to deliver the annual financial plan ……* ☐<br>*5. Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision……* ☐<br>*6. Ineffective understanding and learning following significant events……* ☐<br>*7. Inability to achieve and maintain regulatory compliance, performance and assurance……* ☐<br>*8. Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ |
| CQC DOMAIN | *Which Domain?*<br>*SAFE- People are protected from abuse and harm* ☒<br>*EFFECTIVE - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒<br>*CARING - the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒<br>*RESPONSIVE – the services meet people's needs.* ☒<br>*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 ☐<br>2. Operational Plan ☒<br>3. NHS Compliance ☒ | 4. NHS Constitution ☒<br>5. Equality and Diversity ☐<br>*6.* Other: Cheshire and Merseyside LMS strategy |
| | | |
| 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 assurance on the progress to date of the Better Births project arising from the National Maternity Review* | |
| PREVIOUSLY CONSIDERED BY: | Committee name | Not Applicable<br>Or type here if not on list:<br>*Click here to enter text.* |
| | Date of meeting | *Click here to enter a date.* |
| | | |

## Executive Summary

This paper is to provide an update to the Board of Directors to the progress of the community redesign project and to provide an update on the implementation of recommendations from the National Maternity Review "Better Births". The community redesign aims to ensure that our services meet the needs of women and families, providing a service that offers choice, high quality, safe and effective care. The recommendations from Better Births: improving outcomes of maternity services in England (NHS England 2016), the report of the National Maternity Review is one of the key drivers in shaping the maternity service going forward.
Other significant drivers include:

- NHS 10 year forward plan – Comprehensive Maternity section.
- CQC recommendations following inspection in 2015
- Current NICE guidance
- Cheshire and Merseyside Women's and Children's Partnership (LMS)
- Healthy Liverpool Programme
- Future Generations – Liverpool Women's Hospital
- Early Adopter site status.
- Each Baby Counts
- Saving Babies Lives – Care Bundle

## Report

Better births sets out a vision for safe, efficient models of Maternity care: safer care, joined up across disciplines, reflecting women's choices and offering continuity of care along the pathway. Commissioners are asked to work across areas as local Maternity systems (LMS). The aim is to ensure women have equitable access to the services they choose and need, as close to home as possible.

**The review calls for:**

**1. Personalised care** – women should have a personalised care plan and use of a digital maternity tool. They suggest a 'NHS Personal Maternity Care Budget' which would allow women to choose the provider of their care.

**2. Continuity of care** - every woman should have a midwife who follows her through her pregnancy and each team of midwives should have an identified obstetrician. (This has recently been enhanced and more prescriptive following recommendations from Kirkup and the National Maternity review, regarding 20% of all bookable women are required to be part of a care stream providing all aspects of midwifery care).

**3. Safer care** – each board should have a champion for maternity services and teams should routinely collect data on the quality and outcomes of their services. A national standardised investigation process is also needed for when things go wrong.

**4. Better postnatal and perinatal mental health care** – they call for significant investment in perinatal and post-natal mental health services.

**5. Multi-professional working** - multi-professional learning should be a core part of all pre-registration training for midwives and obstetricians and electronic maternity record should be rolled out.

**6. Working across boundaries** - community hubs should be established creating a one-stop shop for women. They also call for clinical networks where professionals, providers and commissioners can come together on a larger geographical area.

**7. A payment system that fairly and adequately compensates provider**s **for delivering high quality care to all women efficiently** - the review acknowledges that different services in different areas have different cost structures and states that the money needs to follows the woman and her baby as far as possible, to ensure women's choices drive the flow of money, whilst supporting organizations to work together.

**LWH position against Better Births – Appendix 1**

| Recommendation | Trust position | Actions |
|---|---|---|
| 1. Personalised Care | Compliant | • Further actions: The Directory of Services have replaced the Personalised maternity care budgets and have now been approved by the Vanguard and Heads of Midwifery – this is set to be rolled out across Cheshire and Merseyside as a digital tool to allow women to choose provider, as part of the LMS work streams. |
| 2. Continuity of Care | Compliant with NHSE target of 20% of women booked onto a COC pathway by March 19 | • The Current community midwife teams provide antenatal and postnatal continuity for women in their care. However the Better Births calls for a continuity of carer model which follows the woman and her family through her pregnancy journey through the antenatal, intrapartum and postnatal period.<br>• Identification of phase 1 care streams completed. (LINK clinic, Home Birth team, Elective CS).<br>• Further continuity of care models to be implemented to meet maternity datasets. Phase 2 identification: Low risk offer, Diabetes, multiple pregnancy and Rainbow (birth after fetal loss).<br>• Ambition and trajectory completed to meet the NHSE target that 35% of women are booked onto a COC pathway by March 2020.<br>• Staff engagement and consultations underway to review models of care for women to achieve the 35% and 75 %( BAME) NHSE target.<br>• |
| 3. Safer Care | Compliant | • Designated each baby counts process<br>• Board level non-executive Maternity Safety Champion<br>• Director of Nursing and Midwifery heading safer care for maternity services |
| 4. Better Postnatal and perinatal Mental health | Compliant | • Perinatal mental health specialist midwife in post working collaboratively with perinatal mental health team.<br>• Perinatal mental health guidelines and referral pathway under review to reflect regional pathway.<br>• CPN and Psychologist support available to women<br>• Strengthened Consultant presence through links with Merseycare<br>• Nominated Consultant Obstetrician, leading joint MDT clinics, which will operationally deliver this service through our community hubs. |

| Recommendation | Trust position | Actions |
|---|---|---|
| **5. Multi Professional Working (including Electronic patient record)** | Compliant | • Human Factors multi-disciplinary training is being delivered and well received by staff as part of the maternity safety funding.<br>• Pre-hospital emergency course to be delivered 2019 working collaboratively with other neighboring trusts and NWAS this will provide multi-disciplinary collaborative training for community midwives and paramedics on obstetric emergencies in the community setting. |
| | Partially compliant (Due to IT implementation) | • Digital maternity hand held notes part of the EPR project, at present unable to give a time to delays within the project. |
| **6. Working across boundaries** | Compliant (For LWH Trust)<br>Noncompliance noted for CCG's | • We are part of the Early adopter Vanguard for Cheshire and Merseyside.<br>• Successful bid for Community hub in the north of the city including free standing MLU, and community offer.<br>• Work expected on pop up midwife led unit St Chads – to start December 2018.<br>• Engaging with Commissioners to look at cross boundary working to support women in their choice of provider for all aspects of maternity care.<br>• Engaging with the Clinical care streams within the CM vanguard to share best practice and implement best practice.<br>• To explore a team of midwives to provide continuity of care in the antenatal and postnatal period for women choosing to give birth at LWH but who live across geographical boundaries<br>• Joint Consultant posts between two maternity providers, in consultation, standardized maternity roles within support workers across the CM footprint. |
| **7. A payment system that fairly and adequately compensates providers for delivering high quality care to all women efficiently** | Non-Compliant | • Awaiting clarification from a national perspective in relation to maternity tariff payments, we have requested information regarding COC care streams for tertiary level maternity providers.<br>• We have secured additional funding of 14k to operationally deliver phase 2 of COC from NHS E. |

The results of the National Maternity review overwhelmingly noted that continuity of care was the single biggest request from women throughout the review of all maternity services within the United Kingdom. The national maternity review set out a clear recommendation that all maternity providers, should roll out continuity of carer, starting at 20% of all bookable women should be part of a COC care stream. NHS E have provided maternity units with evidence regarding the

outcome data in respect of higher satisfaction rates for service users, and also the clinical outcomes of continuity of care.

## Continuity of Care progress including update of Community redesign

In December 2017 Implementing Better Births: Continuity of Carer set out guidance for Local Maternity Systems to define and implement continuity of carer based on a local ambition and trajectory. To help generate momentum and ensure that the NHS is on track to deliver the ask that most women receive continuity of carer by March 2021, Refreshing NHS Plans for 2018/19 (p30) requires LMS to ensure that from March 2019, 20% of women at booking are placed onto continuity of carer pathways and receive continuity of the person caring for them during pregnancy, birth, and postnatally. This is increased to 35% of women booked onto a continuity of carer pathways by March 2020. Liverpool Women`s are piloting a variety of care models to deliver the target and have achieved over 20% of women booked onto a COC pathway in March 2019 ( Appendix 1 ).

Liverpool Women` have submitted the attached Continuity of Care ambition and trajectory to the LMS to ensure it is on track to deliver the request that 35% of women will be booked on a COC clinical pathway by March 2020. Described below is the LWH COC maternity care streams and how we envisage operational delivery of this mandated NHS E target, including community redesign, to support us in our delivery.

Copy of May Continuity Template.›

## Midwife at Home team established 26th November

The current home birth rate is currently around 1% of the total births, we recognise that we need to increase the uptake of home births and more importantly, the offer of home birth to women accessing LWH maternity services. We have already redesigned our home birth offer, and phase 2 COC work stream of the low risk midwifery offer has commenced, which will include care within MLU and the introduction of low risk MLU/community midwifery teams.

We also recognise that women may choose to access this home birth service throughout any part of the AN journey, and we feel by the modal of care and modal of midwifery staffing we are offering, within the home birth team, women will feel supported in their birth choice. The team consists of 6 WTE midwives who provide continuity of care, this team care for women from initial booking to birth to postnatal services.

The caseload for each WTE midwife is 35-40 women, this is based on birth rate+ and equates to approximately 4 births per WTE midwife per month. For a team of 6.2 this caseload equates to approximately 217-248 women.

The team work's flexibly and self -manage their workload and time based on the woman`s individual care needs, which mirrors a care pathway of independent midwifery providers, and offers women the same care package under a clearly defined low risk clinical pathway, providing an escalation to intermediate/high risk if a women's risk profile changes. This can include antenatal visits and bookings at a suitable venue of the woman`s choice, visits at a time to suit the women, providing on call cover during the day and night for women requesting a birth at home and providing drop in education appointments at local hubs and parent education classes tailored to women considering a birth at home. Time management and caseloads will be

monitored on a weekly basis by the team leader and community matron. Community on calls will be redesigned as part of this care stream with a proposed reduction in general on calls for midwifery staff, as part of the community CIP programme. Presently, this is at staff consultation stage.

## Link Team

Within LWH, 30% of bookable women access maternity services and English is not their first language, this clinic is known as the LINK clinic, it comprises of midwives, medical staff, translators, community support workers employed by the local authority. We will operational change this service in line with national and local intelligence regarding non English speaking women, to negate the risks associated with Non English speaking women, which include a high DNA rate, late booking due to difficulties in accessing health care, we aim by changing the profile of this service to increase BF rates, increase AN attendance in the first 13 weeks, and an increase in SGA detection rate.
Work has commenced, to introduce a social prescribing modal of care to support this vulnerable group, we have undertaken engagement works within these communities and understand what women and families require from a maternity service. We have applied for ESOL funding through the Vanguard and await a decision. We have also undertaken collaborative working with the local GPs to understand issues with access and continuity and aim to provide this vulnerable group a 'one stop shop' service, including, benefits advice, healthy eating, social isolation. We are part of a CCG pilot project in combination with the Citizens advice bureau, to provide a 'rapid response' for families who declare poverty or financial hardship during their pregnancy.

The current midwifery model of care- All Non English speaking women attend for all the AN care to a specialised clinic held at LWH weekly. The clinic is run by a consultant and varied midwives who work in ANC. The women do not have a designated midwife to provide antenatal care and see a member of their midwife team postnatally. The women do not receive a home visit at 36 weeks due to difficulty with interpreters at home and capacity. The 36 week birth visit is discussed at the Link clinic.

The proposed new model of care consists of a team of midwives to provide COC to the most vulnerable women who do not have English as their first language. To ensure continuity for all women attending Link clinic the team also staff the LINK clinic every Monday- this ensures all women see the same team and increase expertise in this area.

The team of 4 WTE provide a birth visit at home to the most vulnerable Non English speaking women at 34 weeks gestation. This is to discuss birth plans, review home circumstances, postnatal support and safe sleep advice. The team also provide postnatal continuity to the women on the caseload. Further work is required as part of phase 2 COC to review the model to provide full Continuity of care throughout the antenatal, intrapartum and postnatal period.

## Elective caesarean section team

The Next birth after caesarean section (NBAC) COC pathway involves antenatal and postnatal care provided by the named midwife on community and intrapartum care provided by a team of midwives in the hospital. The NBAC team provide intrapartum continuity by meeting the women who are planned for CS in the antenatal period for pre- operative advice and parent education- this is from direct patient feedback and women and families are part of the process for tailoring

this bespoke parent education. The team also rotate to provide intrapartum care during planned caesarean sections to women and provide postnatal support on the maternity ward to the women to support the enhanced recovery pathway. The team have received excellent feedback and positive comments from women and staff since they have begun this pilot model which has demonstrated some excellent aspects of continuity, this model of care has also reduced the overall complaint rate within maternity base.

Further review of the team, as part of phase 2 COC, is required to include women who choose to have a vaginal birth after CS and postnatal care in the community and community discharge and wound review clinics. This will require a review of the current staffing in the team and ways of working.

**Women booked on a midwife led pathway.**

In order to meet NHSE target that >35 % of women booked onto a COC pathway by March 2020, LWH are reviewing Continuity of Carer pathways for women booked under midwife led care. Approximately 63% of women booked at the Liverpool Women`s book under a midwife led pathway each month.

- Informal consultations currently underway with staff and HR and staff side reviewing varied models of care June – October 2019
- A financial analysis of the proposed models to be undertaken by September 2019.
- Formal consultations proposed November 2019
- Roll out of new models of care Jan-March 2020

**Evaluation /Monitoring of Data by maternity services**

The *'Better Births; Monitoring the implementation of continuity of carer'* v6 report which has introduced a standardised framework to help Local Maternity Systems and the Maternity Transformation Programme to measure, consistently, the level of continuity of carer being provided over time, not only to monitor delivery, but also to help evaluate the extent to which particular models realise the benefits set out in evidence. This will be monitored by the Maternity Clinical group, and by the safety senate. Work is currently in progress with the information team to record the information required on Meditech. This will allow accurate recording of the data for the maternity dataset and framework which is required to be submitted to the LMS by March 2019.

**Free standing Midwife led unit /Community Hub**

LWH have been successful with two external bids as part of the Cheshire and Merseyside LMS work streams, for wave 2 of improving care across the region.

- Bid 1 – We have been successful to provide a free standing MLU in the north of the city (Kirkby St Chads), as part of a midwifery community hub offer. This will allow women choice of four places of birth as recommended by the National Maternity Review and will provide the opportunity for women to exercise choice and personalisation for their

maternity care and will allow babies to continue to be born locally whilst providing the best start in life through a holistic approach to the delivery of, antenatal, postnatal care. The community hub will also offer care closer to home, clinical initiatives, postnatal clinics, EON clinics, which sits as part of the CIP programme for community services. The maternity community hub will also improve the universal maternity offer to the women and families of Liverpool and Knowsley, by better co-ordination, more consistency, and increased consultation and collaboration between services, which will all be housed within one location.

Services to be provided in the hub will include infant feeding, tongue tie clinic, community clinics (midwifery), extended booking hours, aromatherapy clinic, a safeguarding hub, post-natal clinics (midwifery) PNMH clinics and midwife assessment clinics. The recognised delay has been with NHS Estates work has now started after consultation with the Landlord (non NHS owned building).

- Bid 2 – as part of the Children's Transformation Board winning bid, we are part of the collaboration of hospitals/services that will offer to provide more community led care for the 0-19 children of the city, in a bid to improve overall children's well-being. For maternity services this will include bespoke midwife clinics in the designated areas of Garston/Speke and Aintree, again in an aim to provide care closer to home. This is virtual hub modal with no geographical base; we await the findings of the final consultation to allow maternity to plan for implementation of a community hub modal within these areas.

**IT update (As part of community redesign)**

- New mobile phones now rolled out to community midwives and support workers – on-going issues with WIFI and equipment, escalated to DON, meeting with interim CIO in the diary to discuss and plan a solution.

- Discussions in place with IT project management team to explore introduction of electronic scheduling office 365 for postnatal contacts, as a way to negate some of the above noted issues.

**Conclusion**

A significant number of developments have been made to support the recommendations from the National Maternity Review as part of the community redesign. Ongoing work across Cheshire and Merseyside partnership is intrinsically linked to the redesign of community services at LWH and will continue to steer some of the work streams. This includes the implementation of continuity of care across the LMS, the development of community hubs, development of digital apps and the implementation of the single point of access to allow women to exercise choice.

NHS England

**Maternity Tranformation Programme**
**Continuity of Carer May 19 Deliverable**

**Instructions for Regional Boards**
Please enter the data relating to women booking onto a continuity of carer pathway for each provider for May 2019 in the table below.
Please add any comments in the final column of the table, along with any provider/LMS mappings for correction.
**Please return by 19 June 2019 to england.maternitytransformation@nhs.net.**

Definitions
1) For the purposes of this exercise, a continuity of carer pathway is where a woman can expect to see the same lead/buddy midwife, or a midwife from a defined team of up to 8 midwives over the course of their antenatal, intrapartum and postnatal care.
2) Trusts are asked to count the bookings and placements that occur in May. Bookings or placements onto continuity of carer pathways that occur before May are not to be counted

| | | | A | B | C | Numerator | Denominator | Indicator | |
|---|---|---|---|---|---|---|---|---|---|
| Code | Provider Name | LMS | The number of women who are placed onto a continuity of carer pathway at a booking appointment in May | The number of women who in May are placed onto a continuity of carer pathway after the antenatal booking appointment. | The total number of women booking for maternity care in May | The number of women who are placed onto a continuity of carer pathway at a booking appointment in May, and the number of women who in May are placed on a continuity of carer pathway after the antenatal booking appointment, irrespective of gestational age. (A+B) | The number of women booking for maternity care in May + the number of women who in May are placed onto a continuity of carer pathway after the antenatal booking appointment (B+C) | Proportion of women who are booked or are placed onto a continuity of carer pathway (numerator / denominator) | Comments |
| | | | May-19 | May-19 | May-19 | May-19 | May-19 | May-19 | |
| RY2 | Bridgewater Community Healthcare NHS Foundation Trust | Cheshire and Merseyside | | | | 0 | 0 | - | |
| RJR | Countess Of Chester Hospital NHS Foundation Trust | Cheshire and Merseyside | | | | 0 | 0 | - | |
| REP | Liverpool Women's NHS Foundation Trust | Cheshire and Merseyside | 87 | 130 | 764 | 217 | 894 | 24.3% | |
| RBT | Mid Cheshire Hospitals NHS Foundation Trust | Cheshire and Merseyside | | | | 0 | 0 | - | |
| NDE | One To One (North West) Limited | Cheshire and Merseyside | | | | 0 | 0 | - | |
| RVY | Southport And Ormskirk Hospital NHS Trust | Cheshire and Merseyside | | | | 0 | 0 | - | |
| RBN | St Helens And Knowsley Hospital Services NHS Trust | Cheshire and Merseyside | | | | 0 | 0 | - | |
| RWW | Warrington And Halton Hospitals NHS Foundation Trust | Cheshire and Merseyside | | | | 0 | 0 | - | |
| RBL | Wirral University Teaching Hospital NHS Foundation Trust | Cheshire and Merseyside | | | | 0 | 0 | - | |
| RXP | County Durham And Darlington NHS Foundation Trust | Durham, Darlington and Tees, Hambleton, Richmondshire and Whitby | | | | 0 | 0 | - | |
| RVW | North Tees And Hartlepool NHS Foundation Trust | Durham, Darlington and Tees, Hambleton, Richmondshire and Whitby | | | | 0 | 0 | - | |
| RTR | South Tees Hospitals NHS Foundation Trust | Durham, Darlington and Tees, Hambleton, Richmondshire and Whitby | | | | 0 | 0 | - | |
| RMC | Bolton NHS Foundation Trust | Greater Manchester | | | | 0 | 0 | - | |
| RJN | East Cheshire NHS Trust | Greater Manchester | | | | 0 | 0 | - | |
| R0A | Manchester University NHS Foundation Trust | Greater Manchester | | | | 0 | 0 | - | |
| RW6 | Pennine Acute Hospitals NHS Trust | Greater Manchester | | | | 0 | 0 | - | |
| RWJ | Stockport NHS Foundation Trust | Greater Manchester | | | | 0 | 0 | - | |
| RMP | Tameside And Glossop Integrated Care NHS Foundation Trust | Greater Manchester | | | | 0 | 0 | - | |
| RRF | Wrightington, Wigan And Leigh NHS Foundation Trust | Greater Manchester | | | | 0 | 0 | - | |
| RWA | Hull And East Yorkshire Hospitals NHS Trust | Humber, Coast and Vale | | | | 0 | 0 | - | |
| RJL | Northern Lincolnshire And Goole NHS Foundation Trust | Humber, Coast and Vale | | | | 0 | 0 | - | |
| RCB | York Teaching Hospital NHS Foundation Trust | Humber, Coast and Vale | | | | 0 | 0 | - | |
| RXL | Blackpool Teaching Hospitals NHS Foundation Trust | Lancashire and South Cumbria | | | | 0 | 0 | - | |
| RXR | East Lancashire Hospitals NHS Trust | Lancashire and South Cumbria | | | | 0 | 0 | - | |
| RXN | Lancashire Teaching Hospitals NHS Foundation Trust | Lancashire and South Cumbria | | | | 0 | 0 | - | |
| RTX | University Hospitals Of Morecambe Bay NHS Foundation Trust | Lancashire and South Cumbria | | | | 0 | 0 | - | |
| RLN | City Hospitals Sunderland NHS Foundation Trust | Northumberland, Tyne and Wear and North Durham | | | | 0 | 0 | - | |
| RR7 | Gateshead Health NHS Foundation Trust | Northumberland, Tyne and Wear and North Durham | | | | 0 | 0 | - | |
| RTF | Northumbria Healthcare NHS Foundation Trust | Northumberland, Tyne and Wear and North Durham | | | | 0 | 0 | - | |
| RE9 | South Tyneside NHS Foundation Trust | Northumberland, Tyne and Wear and North Durham | | | | 0 | 0 | - | |
| RTD | The Newcastle Upon Tyne Hospitals NHS Foundation Trust | Northumberland, Tyne and Wear and North Durham | | | | 0 | 0 | - | |
| RFF | Barnsley Hospital NHS Foundation Trust | South Yorkshire and Bassetlaw | | | | 0 | 0 | - | |
| RP5 | Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Tr | South Yorkshire and Bassetlaw | | | | 0 | 0 | - | |
| RHQ | Sheffield Teaching Hospitals NHS Foundation Trust | South Yorkshire and Bassetlaw | | | | 0 | 0 | - | |
| RFR | The Rotherham NHS Foundation Trust | South Yorkshire and Bassetlaw | | | | 0 | 0 | - | |
| RCF | Airedale NHS Foundation Trust | West Yorkshire | | | | 0 | 0 | - | |
| RAE | Bradford Teaching Hospitals NHS Foundation Trust | West Yorkshire | | | | 0 | 0 | - | |
| RWY | Calderdale And Huddersfield NHS Foundation Trust | West Yorkshire | | | | 0 | 0 | - | |
| RCD | Harrogate And District NHS Foundation Trust | West Yorkshire | | | | 0 | 0 | - | |
| RR8 | Leeds Teaching Hospitals NHS Trust | West Yorkshire | | | | 0 | 0 | - | |
| RXF | Mid Yorkshire Hospitals NHS Trust | West Yorkshire | | | | 0 | 0 | - | |
| RNL | North Cumbria University Hospitals NHS Trust | West, North and East Cumbria | | | | 0 | 0 | - | |

| LMS | A | B | C | Numerator | Denominator | Indicator |
|---|---|---|---|---|---|---|
| Cheshire and Merseyside | 87 | 130 | 764 | 217 | 894 | 24.3% |
| Durham, Darlington and Tees, Hambleton, Richmondshire and Whitby | 0 | 0 | 0 | 0 | 0 | - |
| Greater Manchester | 0 | 0 | 0 | 0 | 0 | - |
| Humber, Coast and Vale | 0 | 0 | 0 | 0 | 0 | - |
| Lancashire and South Cumbria | 0 | 0 | 0 | 0 | 0 | - |
| Northumberland, Tyne and Wear and North Durham | 0 | 0 | 0 | 0 | 0 | - |
| South Yorkshire and Bassetlaw | 0 | 0 | 0 | 0 | 0 | - |
| West Yorkshire | 0 | 0 | 0 | 0 | 0 | - |
| West, North and East Cumbria | 0 | 0 | 0 | 0 | 0 | - |

| Region | A | B | C | Numerator | Denominator | Indicator |
|---|---|---|---|---|---|---|
| North | 87 | 130 | 764 | 217 | 894 | 24.3% |

| Agenda Item | 2019/109(i) |
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| **MEETING** | **Board of Directors** |
| **PAPER/REPORT TITLE:** | Safer Nurse/Midwife Staffing Monthly Report |
| **DATE OF MEETING:** | Thursday, 04 July 2019 |
| **ACTION REQUIRED** | **Assurance** |
| **EXECUTIVE DIRECTOR:** | Caron Lappin, Director of Nursing and Midwifery |
| **AUTHOR(S):** | Janet Brennan, Deputy Director of Nursing and Midwifery |
| | |
| **STRATEGIC OBJECTIVES:** | ***Which Objective(s)?***<br>1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐<br>2. To be ambitious and *efficient* and make the best use of available resource ☐<br>3. To deliver *safe* services ☒<br>4. To participate in high quality research and to deliver the most *effective* Outcomes ☐<br>5. To deliver the best possible *experience* for patients and staff ☒ |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | ***Which condition(s)?***<br>***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒<br>***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒<br>***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐<br>***4.*** *Failure to deliver the annual financial plan ……* ☐<br>***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐<br>***6.*** *Ineffective understanding and learning following significant events……* ☐<br>***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒<br>***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ |
| **CQC DOMAIN** | ***Which Domain?***<br>***SAFE-*** *People are protected from abuse and harm* ☒<br>***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒<br>***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒<br>***RESPONSIVE –*** *the services meet people's needs.* ☒<br>***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.*<br>***ALL DOMAINS*** ☐ | |
| **LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT** | **1.** Trust Constitution ☐<br>**2.** Operational Plan ☒<br>**3.** NHS Compliance ☒ | **4.** NHS Constitution ☒<br>**5.** Equality and Diversity ☒<br>***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:**<br>***(eg: The Board/Committee is asked to:-….)*** | The Board is asked to be assured:<br>• that appropriate information isbeing provided to meet the national and local requirements; and<br>• that the Trust 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.***<br>Or type here if not on list:<br>***Click here to enter text.*** |
| | **Date of meeting** | ***Click here to enter a date.*** |
| | | |

## Executive Summary

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

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

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

The use of CHPPD as a benchmark within and against other organisations is still under development by NHS Improvement and subsequent reports will be amended accordingly, presently CHPPD is featured alongside fill rates for each ward and department.

Care hours per day remain at a sustained level indicating a consistent level of care nursing/midwifery resource to provide care to our patients. The staffing across the inpatient ward areas for May 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. It has been agreed that maternity can over establish by 10 midwives to cover maternity leave.
- The trust has introduced a ward accreditation system which is required to support the collection of quality indicators alongside real time patient safety flags. Ward accreditation baseline assessment was rolled out to 5 areas in April 2019.
- 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 **May 2019.**

- Gynaecology has seen an slight decrease increase in fill rate from  but still > 90%
- Delivery suite and maternity base have seen an increase in fill rates for RM but a slight decrease of care staff.
- MLU and Jeffcoate has seen a decrease in support worker fill rate
- Neo- natal has remained static with a very good fill rate.

Staffing is monitored across maternity every 2 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. The Neo-natal unit uses an acuity model of staffing which is used every 12 hours.

**2.2 Red Flags**

**May 19 – Red Flags**
There were a total of 9 incidents reported under the Nursing / Midwifery red flag criteria.  3 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. 8.7 WTE vacancies on the Gynaecology Ward however, 4.0 WTE on maternity leave.  3.88 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 May 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 receive the paper for information and discussion.

Liverpool Women's NHS Foundation Trust

# Appendix 1

May 2019

| WARD | Fill Rate Day% RN/RM | Fill Rate Day % Care staff | Fill Rate Night % RN/RM | Fill Rate Night % Care staff |
|---|---|---|---|---|
| **Gynae Ward** | 94.4% | 90.5% | 100% | 110% |
| **Delivery Suite** | 90.1% | 68.8% | 93.3% | 68.8% |
| **Mat Base** | 96.8% | 81.5% | 92.6% | 82.9% |
| **MLU** | 98.4% | 64.5% | 96.8% | 41.9% |
| **Jeffcoate** | 80.6% | 71% | 74.2% | 38.7% |
| **Neo-nates** | 112.3% | 106.5% | 109.1% | 101.6% |

| Agenda Item | 2019/109(ii) |
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| **MEETING** | **Board of Directors** |
| **PAPER/REPORT TITLE:** | **Bi-Annual Nursing & Midwifery Staffing Report June 2019** |
| **DATE OF MEETING:** | Monday, 24 June 2019 |
| **ACTION REQUIRED** | **For Assurance** |
| **EXECUTIVE DIRECTOR:** | Caron Lappin, Director of Nursing and Midwifery |
| **AUTHOR(S):** | Caron Lappin, Janet Brennan |
| | |
| **STRATEGIC OBJECTIVES:** | ***Which Objective(s)?***<br>1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒<br>2. To be ambitious and *efficient* and make the best use of available resource ☒<br>3. To deliver *safe* services ☒<br>4. To participate in high quality research and to deliver the most *effective* Outcomes ☐<br>5. To deliver the best possible *experience* for patients and staff ☒ |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | ***Which condition(s)?***<br>***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐<br>***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒<br>***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐<br>***4.*** *Failure to deliver the annual financial plan ……* ☐<br>***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐<br>***6.*** *Ineffective understanding and learning following significant events……* ☐<br>***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒<br>***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ |
| **CQC DOMAIN** | ***Which Domain?***<br>***SAFE-*** *People are protected from abuse and harm* ☐<br>***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐<br>***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐<br>***RESPONSIVE –*** *the services meet people's needs.* ☐<br>***WELL-LED -*** *the leadership, management and governance of the* ☐ |

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|---|---|---|---|---|
| | *organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.*<br>***ALL DOMAINS*** ☒ | | | |
| **LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT** | **1.** Trust Constitution ☐<br>**2.** Operational Plan ☒<br>**3.** NHS Compliance ☒ | | **4.** NHS Constitution ☐<br>**5.** Equality and Diversity ☒<br>***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:**<br>***(eg: The Board/Committee is asked to:-….)*** | The Board is asked to:<br>*1. receive assurance on the current nurse/ midwife staffing levels*<br>*2. receive assurances provided that nurse/midwife staffing levels are safe and appropriate at present.*<br>*3. recognise the risk to the organisation of the number of nursing and midwifery staff > 50 years of age.*<br>*4. Be cited on the national shortage of nurses and midwives.* | | | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee name** | Putting People First Committee | | |
| | **Date of meeting** | Monday, 24 June 2019 | | |
| | | | | |

**Executive Summary**

The bi-annual Nursing and Midwifery staffing report is provided to the Board of Directors through the Putting People First (PPF) Committee. The report sets out the LWH position in the context of the National Nursing and Midwifery workforce challenges. The paper covers the period from January 2019 to May 2019. Due to the timings of the PPF and the available data it has been agreed that there will be a report in June and January each year which means the data will be for 5 months and 7 months. The paper provides assurance that there are robust systems and processes in place throughout the year to monitor and manage nursing & midwifery staffing requirements.

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

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

- Must deploy sufficient suitable qualified competent, skilled and experienced staff to meet the care

and treatment needs safely and effectively.

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

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

LWH reports the following in line with NQB recommendations:

- 6 monthly Trust Board report: Bi- annual Nursing & Midwifery Staffing Review.
- Monthly Board level reporting detailing planned and actual staffing for the previous month.
- Monthly staffing report to Unify and published on the Trust's website, and the NHS Choices website.
- Nursing/ Midwifery staffing levels each shift (planned and actual) displayed at ward level.
- Evidence based tools, professional judgement and outcomes are used in the safe staffing processes.
- Updated annual workforce plan that is signed off by the Executives. ( reported January 2019 )
- Any service change, including skill mix change has a full quality impact assessment review signed off by the DONM and MD.

The report highlights:

- A review was undertaken in maternity by Birth rate plus and the recommendations were agreed by Board.
- Theatres establishment follows Association for perioperative Practice (AFPP) guidelines.
- The Trust has joined NHSI cohort 4 – reviewing retention with an action plan monitored through PPF
- CHPDD shows : LWH average is 12.0 hrs per day spent with patients compared to 12.1 ( Peers) and 11.7 hours (national) based on the Model Hospital Data (February 19)
- Actual versus planned staffing shows: Fill rate average has been 97% for registered staff and 83.5% for unregistered.
- Vacancy rates are below the national picture.
- The Age profile for LWH - 32 % of the Nursing and Midwifery workforce are > 50 years of age.

The paper has been reviewed by the Putting People First Committee at its meeting on 24 June 2019 and is presented to the Board for review and assurance.

## Report

### 1.0 Introduction

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

**1.2** The paper will provide analysis of the Trusts workforce position at the end of May 2019 and the actions being taken to mitigate and reduce the vacant position.

**1.3** Workforce modelling has been undertaken at budget setting by each division and has been agreed for the financial year 2019/2020.

**1.4** The staffing and acuity measures are modelled twice yearly based on activity and professional judgement. Birth- rate plus and professional judgements are used to determine appropriate midwifery staffing. In addition the maternity delivery suite utilise an acuity tool every two hours to assist with staffing. The Neo-natal unit utilises an acuity model of staffing, which is reviewed 12 hourly and staffing flexed in accordance with patient need. British Association of Perinatal Medicine (BAPM) standards have been utilised to provide the benchmark for staffing within the Neo-natal Unit. Theatre staffing review is based on AFPP (Association of peri-operative practitioners) guidelines.

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

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

**1.7** The introduction of Ward accreditation across 5 areas in April (Maternity Base, Gynaecology Ward, Neo-nates, Delivery and MLU) reviews staffing as part of the accreditation process.

## 2.0 National Context

**2.1** The shortfall in nurse numbers and midwives across the UK is well- recognised. Although there is no nationally agreed measure of the shortfall in the nursing in England, recent figures presented by NHSI suggest the number is circa 43,000 vacancies and 3.500 Midwives. Cheshire and Mersey report > 200 vacancies across the region.

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

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

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

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

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

**2.7** Cheshire and Mersey Vacancy position is 9.3% and the national position is 11.6%.

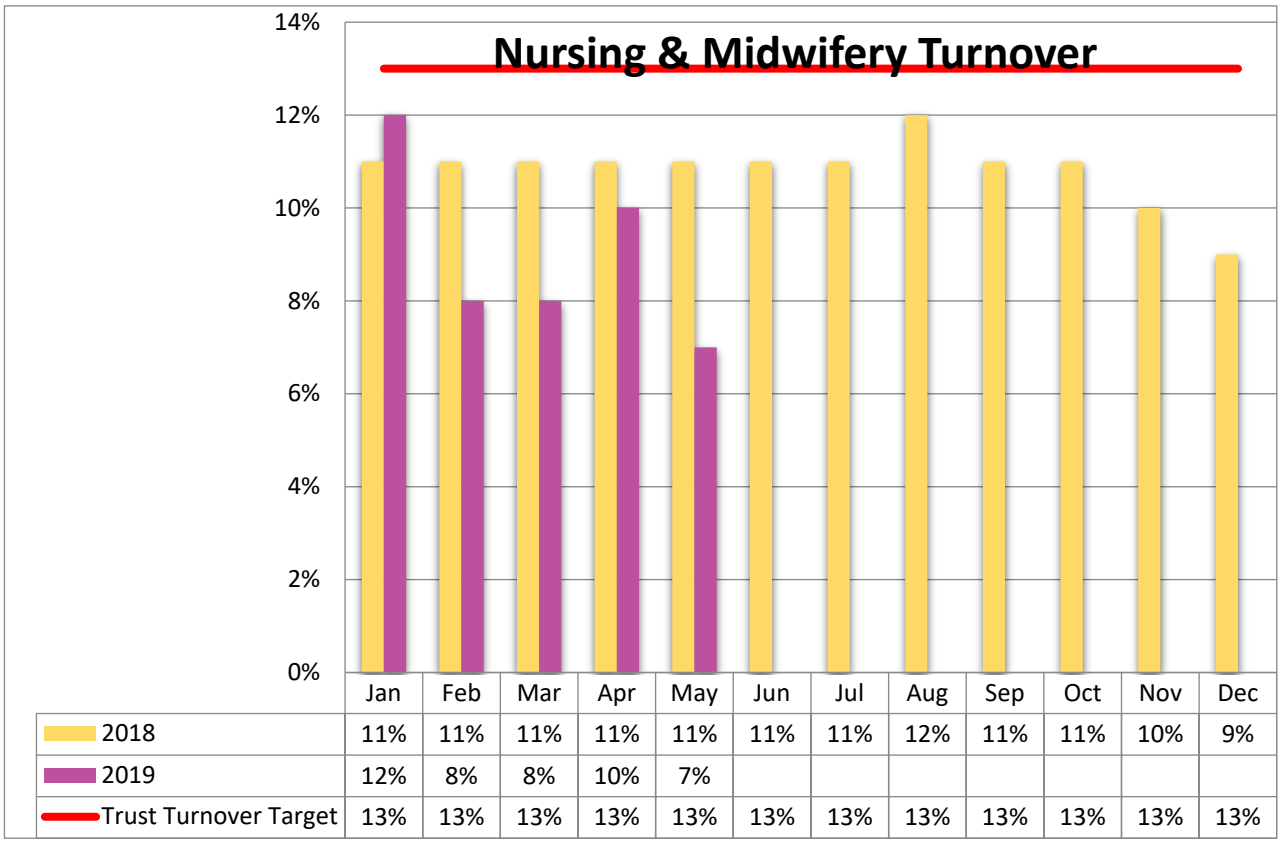
**2.8** The NHS interim people plan (June 2019) recognises the significant shortfalls in nursing and has put in a number of actions to enable the NHS to grow the nursing workforce by >40,000 by 2024 and reducing vacancy levels to 5% by 2028.

## 3.0 LWH Workforce position

**3.1** At the end of May 2019 there were a total of 12.42 wte registered nursing, midwifery and ODP vacancies across LWH. With a vacancy rate of 1.9% compared to Cheshire and Mersey (9.2%) and the national picture (11.6%) LWH is excellent.

**3.2** The tables below illustrate the vacancies, turnover and absence by division (May 2019) and the overall turnover for N&M compared to last year which shows significant improvement.

| RN&M / ODP vacancies | Establishment | In Post | Vacancies | Vacancy rate % | Turnover | Absence |
|---|---|---|---|---|---|---|
| **Maternity** | 280.67 | 289.00 | -8.33 | -2.9% | 5% | 4.75% |
| **Gynaecology** | 94.52 | 85.75 | 8.77 | 9.2% | 8% | 3.11% |
| **Neonates** | 163.62 | 159.74 | 3.88 | 2.3% | 9% | 4.85% |
| **Hewitt** | 33.48 | 34.04 | -0.56 | -1.67% | 12% | 12% |
| **Genetics** | 12.8 | 9.8 | 3.0 | 23% | 0% | 0% |
| **Theatres** | 55.72 | 46.53 | 9.19 | 18% | 12% | 8.15% |
| **Other (Support)** | 2.93 | 6.45 | -2.2 | -75% | 2.6% | 2.55 % |
| **Total** | 643.73 | 631.31 | 12.42 | 1.9% | 7% | 4.78% |

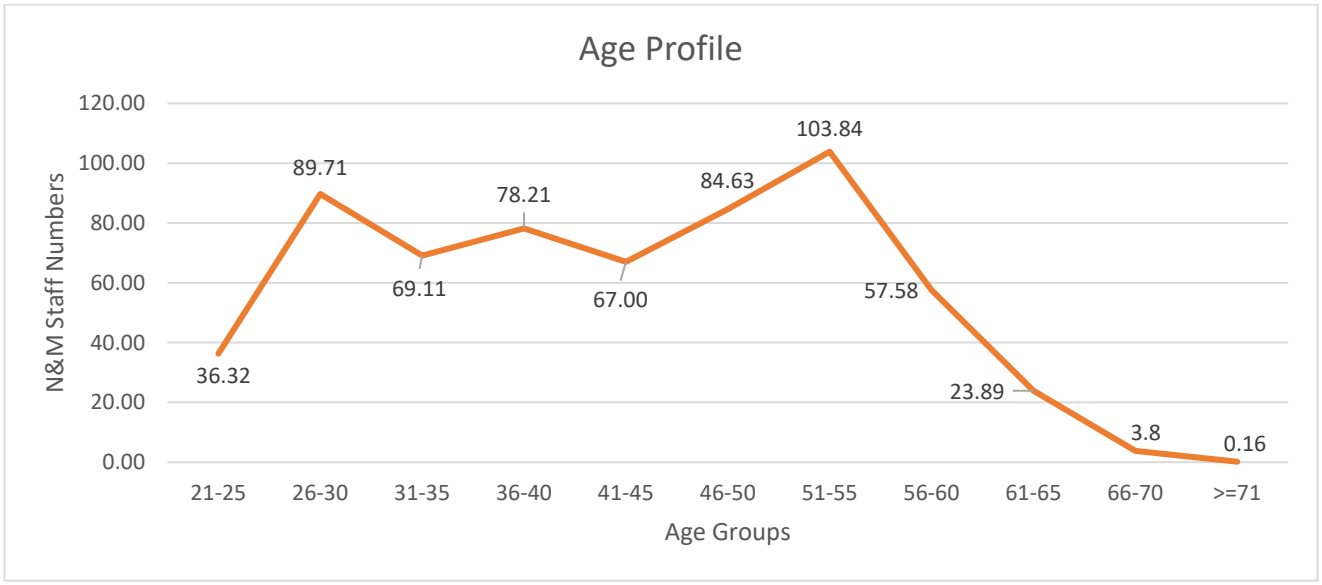



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2018 | 11% | 11% | 11% | 11% | 11% | 11% | 11% | 12% | 11% | 11% | 10% | 9% |
| 2019 | 12% | 8% | 8% | 10% | 7% | | | | | | | |
| Trust Turnover Target | 13% | 13% | 13% | 13% | 13% | 13% | 13% | 13% | 13% | 13% | 13% | 13% |

**3.3** Nursing and Midwifery turnover is 7% at the end of May 2019.

**3.4** There are 9 Registered Nurses/ Midwives in the pipeline to commence in post in the next few months and 6 unregistered staff.

**3.5** Age Profile - the graph below illustrates the age profile of Nurses and Midwives across LWH. 235 of our N&M workforce are between 51-65 years of age which equates to 32% of LWH workforce.



## 4.0 Summary of outcomes from Divisional reviews.

### 4.1 Gynaecology services

Areas of challenge relating to staffing are:

- The Hewitt Centre has seen an improvement in recruitment particularly at the Knutsford site with LWH site supporting led by the Matron.

- Following workforce reviews finance have increased the establishment in Macmillan, GED and Hewitt Fertility centre.

- CHPPD data for the Gynaecology Ward shows an average of 6.46 hrs spent with the patient per day compared to 6.90 (peers) and 7.87 (national) based on data from the Model Hospital (February 19). However, a review of the data from December - May shows an average of 7.4 hours per patient per day. It is important to note that the use of CHPPD will only capture the care hours provided to each bed and does not capture all the activity on the ward such as the turnover of patients through that bed within the 24-hour period or recognise the acuity of the patient receiving the care. CHPPD measures must be reviewed alongside patient acuity and dependency data and professional judgement as CHPPD is not a metric to either determine registered nurse requirements or to provide assurance for safe staffing by itself. The data will be reviewed as part of the workforce review by the HON.

- Recent turnover has decreased from the previous report to 8% (15% previously). Listening events continue held by the HON and as part of the NHSI retention programme Gynaecology are implementing a number of actions.

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

### 4.2 Theatres

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

The role of the First surgical assistant has been introduced and theatres have successfully trained 3 members of staff in this extended role, all achieving qualifications through Edge Hill University. These additional roles are undertaking the role of the junior doctor when required during the perioperative stage. It is intended that these posts will also offer support maternity services. Changes in practice and guidance within the midwifery staffing cohort and NHSI advice has meant previously there has been a reliance on this staffing group to support theatres out of hours. A business case is in process to increase the theatres out of hours staffing.

### 4.3 Maternity

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

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

Staff turnover has been below the trust target, in May 19 it was 5%. The HOM has reviewed all leavers in the last 6 months and the attrition is mainly due to other opportunities overseas. Maternity also have a number of actions as part of the NHSI retention programme to improve on this. Although the vacancy rate is nil, many are newly qualified midwives which is challenging as the level of experience and expertise takes time to develop. The role of Deputy Head of Midwifery has been introduced to strengthen the midwifery leadership team.

### 4.4 Neonatal Services

In line with other intensive care specialities BAPM has set clear standards about the minimum number of nurses required to care for neonates in intensive care. According to BAPM standards with a 25% uplift then the unit should have 124 bedside nurses wte in post there are 124 wte. The unit can sometimes struggle to meet the nursing ratios on a day to day basis and this is due to the current environment and the occupancy of HD and IC which often run on or above the 80% commissioned occupancy. Staffing and Acuity are monitored by the shift co-ordinator and twice a day on the Badger system. As part of the Single service with Alderhey nursing teams are now rotating across sites which is proving successful.

### 4.5 Genetics

There is no national workforce tool for determining staffing levels for genetic counsellors: however, there are various guidance which is taken into consideration when planning safe staffing numbers. There is a national shortage of trained genetic counsellors which has been evident in the previously unsuccessful recruiting to a band 7. However there has been a recent recruitment to the post of Band 7 to commence in July following training.

## 5.0 Recruitment

Trust wide recruitment campaigns continue to attract experienced nurses and midwives as well as newly qualified Nurses and Midwives. There are currently 9 Nurses/ midwives both newly qualified and experienced nurses/ midwives with conditional job offers whose appointments are being

processed through the recruitment process. The HON/ M have introduced keep in touch strategies for those in the recruitment process.

## 6.0 Retention and Turnover

**6.0** Retention is a key element of the workforce plans for the Trust. At the end of May 2019, the Nursing and Midwifery turnover rate was 7 %. This is an improvement of 5.2% from the last report.

**6.1** LWH have joined Cohort 4 of NHSI work regarding retention. An action plan has been developed and is being monitored through the Nursing and Midwifery Professional Forum.

## 7.0 Care Hours Per Patient Per Day (CHPPD)

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

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

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

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

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

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

**7.7** Appendix 1 illustrates CHPPD level from December 2018- May 2019:

| | Average hours per day spent with Patients |
|---|---|
| Delivery suite | 21.8 |
| Maternity Base | 6 |
| MLU | 33.8 |
| Jeffcoate | 8.7 |
| Neonatal unit | 13.3 |

| | |
|---|---|
| Gynaecology Ward | 7.4 |

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

## 8.0 Safe care-Planned versus actual

**8.1** Planned versus actual staffing levels are reported monthly via Unify. Currently the data is gathered manually it is envisaged producing this information via Health roster by the end of Q3.

**8.2** Appendix 1 shows the planned versus actual figures from December 2018- May 2019. The data shows that the fill rate is very good. Averages for RN/M is 97% and care staff fill rate is 83.5%.

## 9.0 Safe care-Acuity and dependency

**9.1** The previous results of the Safer Care Nursing Staffing tool (SCNT) were unable to define the correct establishment needed for the gynaecology ward due to the mix of day cases and in patients but gave an indication for the HON to use as part of the workforce review.

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

## 10.0 Red Flags and escalation

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

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

**10.3** From December 2018- May 2019 a total of 84 Red flags were raised. Of these 20 were incidents reported as staffing shortfalls.

**10.4** The top 3 reporting areas were delivery suite, delivery suite induction room and neonatal unit.

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

## 11.0 E-Roster

**11.1** The Trust has rolled out Health Roster, there is still some work to do with embedding usage of the system. Health roster challenge meetings have commenced with DDON/M, monitoring the roster performance KPI's with the HON/M and matrons. This is now led by the divisions and will be discussed as part of the divisional performance reviews.

## 12.0 Temporary staffing

**12.1** Currently the Trust uses its own internal Bank system. A scoping exercise is currently being undertaken looking at the feasibility and cost of utilising other bank methods it is envisaged the business case will be completed by September 2019.

## 13.0 Headroom

**13.1** The trust previously funded headroom within operational budgets at 18.9%. The board agreed from April in a phased approach to increase the headroom to 21% and 21.4% for maternity (due to the extra mandatory training that must be fulfilled in maternity). Maternity leave is not funded within the headroom calculation. To provide assurance that the increase in headroom is of benefit various KPI's will be monitored. These include mandatory training, appraisal rates and e-rostering KPI's (unavailability and net hours owed).

## 14.0 Summary

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

**14.2** Vacancy rate for N&M at LWH is 1.9% compared to the national picture of 11.6 %.

**14.3** 7% turnover in April compared to 15% across Cheshire and Mersey.

**14.4** 32% of the Nursing and Midwifery workforce are > 50 years of age therefore recruitment and retention needs to remain a high focus.

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

## 15.0 Conclusion / Recommendations

The Board is asked to:

- *receive assurance on the current nurse/ midwife staffing levels*
- *receive assurances provided that nurse/midwife staffing levels are safe and appropriate at present.*
- *recognise the risk to the organisation of the number of nursing and midwifery staff > 50 years of age.*
- *Be cited on the national shortage of nurses and midwives*

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**APPENDIX 1**

**Fill Rate/ CHHPD**

**Dec 18**

| WARD | Fill Rate day% RN/RM | Fill Rate day % Care staff | Fill Rate Night % RN/RM | Fill Rate Night % Care staff | CHPPD RN/RM | CHPPD Care staff | CHPPD Total |
|---|---|---|---|---|---|---|---|
| **Gynae ward** | 87.4% | 92.3% | 95.6% | 94.1% | 6.1 | 4.0 | 10.1 |
| **Delivery suite** | 82.6% | 72% | 84.9% | 71% | 17.5 | 3.0 | 20.5 |
| **Mat Base** | 84.3% | 74.8% | 82.7% | 89.2% | 4.6 | 2.2 | 6.8 |
| **MLU** | 97.6% | 100% | 100% | 96.8% | 23.5 | 5.8 | 29.3 |
| **Jeffcoate** | 90.3% | 74.2% | 80% | 51.6% | 4.1 | 3.1 | 7.2 |
| **Neo-nates** | 102.6% | 79% | 100.4% | 80.6% | 12.3 | 1.2 | 13.3 |
| **Average** | 90.8% | 82.05% | 90.6% | 80.5% | | | |

**Jan 19**

| WARD | Fill Rate Day% RN/RM | Fill Rate Day % Care staff | Fill Rate Night % RN/RM | Fill Rate Night % Care staff | CHPPD RN/RM | CHPPD Care staff | CHPPD Total |
|---|---|---|---|---|---|---|---|
| **Gynae Ward** | 97.5% | 97.8% | 100% | 100% | 4.1 | 2.4 | 6.5 |
| **Delivery suite** | 76.7% | 69.9% | 84.9% | 78.5% | 19.0 | 3.3 | 22.3 |
| **Mat Base** | 94.4% | 78.15% | 98.2% | 90.3% | 5.7 | 2.6 | 8.1 |
| **MLU** | 96.6% | 80.6% | 98.4% | 77.4% | 29.3 | 5.9 | 35.2 |
| **Jeffcoate** | 96.8% | 58.1% | 100% | 64.5% | 6.0 | 3.7 | 9.7 |
| **Neo-nates** | 107.7% | 90.3% | 108.5% | 98.4% | 12.3 | 1.3 | 13.6 |
| **Average** | 95% | 79% | 98.3% | 85% | | | |

**Feb 19**

| WARD | Fill Rate Day % RN/RM | Fill Rate Day % Care staff | Fill Rate Night % RN/RM | Fill Rate Night % Care staff | CHPPD RN/RM | CHPPD Care staff | CHPPD Total |
|---|---|---|---|---|---|---|---|
| **Gynae ward** | 101% | 98.7% | 102.4% | 94.3% | 4.5 | 2.6 | 7 |
| **Delivery suite** | 81.2% | 73.8% | 89% | 75% | 17.8 | 3.1 | 20.9 |
| **Mat Base** | 90.6% | 76.4% | 94.9% | 66.1% | 5.0 | 2.3 | 7.3 |
| **MLU** | 94.6% | 50% | 100% | 78.6% | 27.3 | 4.5 | 31.8 |
| **Jeffcoate** | 100% | 60.7% | 96.4% | 60.7% | 5.6 | 3.5 | 9.1 |
| **Neo-nates** | 109.2% | 92.9% | 105.8% | 96.4% | 11.8 | 1.3 | 13.1 |
| **Average** | 96.1% | 75.3% | 98% | 78.5% | | | |

**Mar 19**

| WARD | Fill Rate Day % RN/RM | Fill Rate Day % Care staff | Fill Rate Night % RN/RM | Fill Rate Night % Care staff | CHPPD RN/RM | CHPPD Care staff | CHPPD Total |
|---|---|---|---|---|---|---|---|
| **Gynae ward** | 100% | 98.4% | 100% | 100% | 4.5 | 2.1 | 6.6 |
| **Delivery suite** | 86.4% | 72% | 93.8% | 72% | 19.1 | 3.3 | 22.3 |
| **Mat Base** | 86.3% | 64.5% | 88% | 83.9% | 4.5 | 2.0 | 6.4 |
| **MLU** | 94.4% | 54.8% | 96.8% | 67.7% | 29.3 | 4.7 | 34 |
| **Jeffcoate** | 96.8% | 67.7% | 93.5% | 48.4% | 6.2 | 3.8 | 9.9 |
| **Neo-nates** | 107.3% | 109.7% | 102.8% | 103.2% | 11.9 | 1.5 | 13.4 |
| **Average** | 95.2% | 77.85% | 95.7% | 79.2% | | | |

**April 19**

| WARD | Fill Rate Day% RN/RM | Fill Rate Day % Care staff | Fill Rate Night % RN/RM | Fill Rate Night % Care staff | CHPPD RN/RM | CHPPD Care staff | CHPPD Total |
|---|---|---|---|---|---|---|---|
| **Gynae Ward** | 99.1% | 98.5% | 100% | 100% | 4.5 | 2.2 | 6.8 |
| **Delivery suite** | 92.9% | 70% | 97.8% | 67.8% | 19.5 | 3.0 | 22.5 |
| **Mat Base** | 92.5% | 92.5% | 93.8% | 76.9% | 4.6 | 2.1 | 6.8 |
| **MLU** | 103.3% | 151.9% | 100% | 166.4% | 30.2 | 5.4 | 35.6 |
| **Jeffcoate** | 137.4% | 94% | 144.7% | 50.6% | 4.1 | 2.1 | 6.2 |
| **Neo-nates** | 102.3% | 116.7% | 104.4% | 85% | 11.3 | 1.4 | 12.7 |
| **Average** | 104% | 103% | 106% | 91% | | | |

**May 19**

| WARD | Fill Rate Day% RN/RM | Fill Rate Day % Care staff | Fill Rate Night % RN/RM | Fill Rate Night % Care staff | CHPPD RN/RM | CHPPD Care staff | CHPPD Total |
|---|---|---|---|---|---|---|---|
| **Gynae Ward** | 94.4% | 90.5% | 100% | 110% | 5.1 | 2.4 | 7.6 |
| **Delivery suite** | 90.1% | 68.8% | 93.3% | 68.8% | 19.3 | 3.1 | 22.4 |
| **Mat Base** | 96.8% | 81.5% | 92.6% | 82.9% | 4.9 | 2.3 | 7.2 |
| **MLU** | 98.4% | 64.5% | 96.8% | 41.9% | 32.7% | 4.5 | 37.2 |
| **Jeffcoate** | 80.6% | 71% | 74.2% | 38.7% | 6.1 | 4.3 | 10.5 |
| **Neo-nates** | 112.3% | 106.5% | 109.1% | 101.6% | 12.5 | 1.5 | 13.9 |
| **Average** | 95.4% | 80.53% | 94.33% | 74% | | | |

| Agenda Item | 2019/110 |
|---|---|

| | |
|---|---|
| **MEETING** | **Trust Board** |
| **PAPER/REPORT TITLE:** | **Performance Report month 2, 2019/20** |
| **DATE OF MEETING:** | Thursday, 04 July 2019 |
| **ACTION REQUIRED** | **For Assurance** |
| **EXECUTIVE DIRECTOR:** | Loraine Turner, Interim Director of Operations |
| **AUTHOR(S):** | Sarah Sherrington, Interim Service Improvement and Business Manager |
| | |
| **STRATEGIC OBJECTIVES:** | ***Which Objective(s)?***<br>1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒<br>2. To be ambitious and *efficient* and make the best use of available resource ☒<br>3. To deliver *safe* services ☒<br>4. To participate in high quality research and to deliver the most *effective* Outcomes ☒<br>5. To deliver the best possible *experience* for patients and staff ☒ |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | ***Which condition(s)?***<br>***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐<br>***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒<br>***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐<br>***4.*** *Failure to deliver the annual financial plan ……* ☐<br>***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒<br>***6.*** *Ineffective understanding and learning following significant events……* ☐<br>***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒<br>***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ |
| **CQC DOMAIN** | ***Which Domain?***<br>***SAFE-*** *People are protected from abuse and harm* ☒<br>***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒<br>***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐<br>***RESPONSIVE –*** *the services meet people's needs.* ☒<br>***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.*<br>***ALL DOMAINS*** ☐ | | | |
| **LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT** | **1.** Trust Constitution ☐<br>**2.** Operational Plan ☒<br>**3.** NHS Compliance ☒ | | **4.** NHS Constitution ☐<br>**5.** Equality and Diversity ☐<br>***6.*** Other: Click here to enter text. | |
| | | | | |
| **FREEDOM OF INFORMATION (FOIA):** | *Choose an item.* | | | |
| | | | | |
| **RECOMMENDATION:**<br>***(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** | *Choose an item.*<br>Or type here if not on list:<br>*Click here to enter text.* | | |
| | **Date of meeting** | *Click here to enter a date.* | | |
| | | | | |

## Executive Summary

This report has been produced to provide a performance position and for the board to be assured of the measures taken to improve the access targets.

Performance improved for sickness, 52 week breaches in month 2 and the 104d target in Month 1. Challenges continue in achieving the 62d cancer and RTT targets. A regional approach to managing the gynae-oncology 62d treatment target is underway with support from the Cancer Alliance. NHSI have provided great reassurance that the Trust is managing the RTT performance in the most clinically appropriate manner and are satisfied with progress made to withdraw supportive involvement to the Trust.

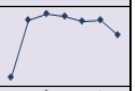
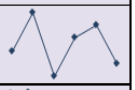
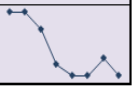
## Report

### 1. Introduction

This report will provide an overview of the Trust's performance against the Board's Key Performance Indicators, highlighting those where the targets have not been met in month and subsequent actions taken to improve this position.

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

## 2. Performance

| INDICATOR | | METRIC | THRESHOLD | | ACTUALS | | | | | | | | Δ | TREND |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | | |
| Cancer | 2WW for suspected cancer | % | ≥93% | Higher values are better | 96.8 | 95.3 | 95.2 | 97.1 | 99.0 | 96.4 | 94.2 | | ▼ |  |
| | 31 Days from Diagnosis to 1st Definitive Treatment | % | ≥96% | Higher values are better | 60.0 | 91.3 | 95.0 | 93.3 | 90.3 | 91.3 | 83.3 | | ▼ |  |
| | 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 | 78.6 | 54.3 | | ▼ |  |
| | 104d Referral to First Definitive Treatment | Count | 0 | Zero tolerance | 2 | 5 | 0 | 3 | 4 | 1 | 0 | | ▲ |  |
| RTT | RTT Incomplete Pathways <18 weeks | % | ≥92% | Higher values are better | 87.1 | 87.2 | 85.9 | 85.5 | 84.9 | 85.1 | 84.6 | 83.0 | ▼ |  |
| | Incomplete Pathway > 52 Weeks | Count | 0 | Zero tolerance | 14 | 14 | 11 | 5 | 3 | 3 | 6 | 3 | ▲ |  |

** Cancer: for all Trusts data every month is submitted to the national data base (CWT) 5 weeks after the month end to ensure the accurate reallocation of the breaches.

Trends therefore cannot incorporate or reflect the May data until the formal submissions are made.

### 2.1 Cancer:

The 2 Week Wait (2WW) target was achieved again in April, however it dipped slightly in month as expected in response to the significant increase of ~50% Colposcopy referrals (high grades), likely due to the launch of the national screening campaign. Demand for high grade colposcopy appointments meant that routine colposcopy work had to be diverted to weekend lists. The effect of the national campaign on referral numbers is being monitored closely to anticipate for any longer-term implications for the service and to enable future planning. Discussions have taken place with PHE and the CCGs to make them aware of the challenges to accommodate such an increase in demand, the sustainability of this position and its' implications more widely on our overall cancer and RTT performance.

May's unvalidated Cancer position indicates improvement in month 2 as colposcopy referrals returned to a historically normal level. The month 2 May data will be available as a fully validated position for national upload by close of business on 4th July. For all Trusts monthly cancer data is submitted to the national data base (CWT) 5 weeks after the month end to ensure the accurate reallocation of the breaches. Trends therefore cannot incorporate or reflect the May data until the formal submissions are made.

There were no 104 day patients recorded in April which is an improvement in month.

### 2.2 Cancer Recovery Plan:

Significant challenges to meet the 62 day targets remain. The achievement of these targets in year is dependent upon both internal and complex external factors (see Appendix 2 for more detail) and as such NHSI IST and the Cancer Alliance have both recognised the need for a regional approach in order to support the delivery of the gynaecology targets. In response to this the Cheshire & Merseyside Cancer Alliance have this month outlined their

commitment to develop and begin implementation of an optimal pathway for gynae-oncology to support work already undertaken by the Trust towards achievement of 28 and 62 day standards and improve patient experience, including the development of a networked approach to pathology and radiology.

Internally, a business case for two new Gynae-Oncology Consultants has been approved following demand and capacity models evidencing that the current Consultant resource is inadequate to meet current referral demand. Timely recruitment of this additional resource this year will be crucial in improving performance and a pivotal factor in the achievement of the 62 day target. Following discussions with LCL (Pathology provider) and assurances given regarding a commitment to improving the turnaround times of pathology results it is anticipated that this with positively impact the cancer waiting times. Discussions have also commenced with RLBUH to negotiate additional theatre lists to treat complex cancer patients in a timely manner.

**2.3 Referral to Treatment (RTT):**

RTT incomplete 18 week pathway performance dipped in April and May as anticipated due to the high influx of Colposcopy high grades referrals and the reduction in activity predicted as a result of one locum Consultant on leave all month, continued long-term sickness of some Consultant staff and the impact of the Easter and May bank holidays.

Capacity issues persist in Uro-Gynaecology with 2 Consultants successfully recruited in March 2019 to address this shortfall. The 2 newly appointed Uro-gynaecology consultants commenced in post in May, with this anticipated to start having an impact in our performance in June.

The priority of the service has been to treat the patients who have been waiting longest for treatment and more clinically urgent, whilst this has seen a reduction in performance against the 18 week RTT, it has seen a positive reduction the number of 52 week breaches.

In May the Trust experienced three 52week breaches due to pop ons. All of the patients were either treated or discharged from the service in month.

**2.4 RTT Recovery Plan:**

The Recovery Plan for RTT has continued in line with the best practice guidance from NHSI IST, which is to focus on reducing the long waiting patients to reduce the clinical risk to those patients. Whilst doing so, it is acknowledged that the 92% target may take longer to recover. In November 2018 IST advised a 16 month recovery plan for RTT due to the long-waiting patient backlog the Trust had, compounded with stabilising business as usual following the two Serious Untoward Incidents in February 2018 and initial demand and capacity modelling evidencing the current workforce was insufficient to meet the current referrals demand (this was excluding the additional work required to clear waiting lists).

NHSI have also recognised that nationally the 92% targets have not been consistently met since 2016. In response to this, and to ensure Trusts are taking a clinical safety focussed approach to managing waiting lists, NHSI are currently revising the 92% target with a view to abolishing this in favour of introducing a mean waiting time target later this year. This new target is currently being piloted in test sites nationally before implementation.

The Trust has received acknowledgement of good progress and practice in managing the RTT position by prioritising the management of long waiting patients. The Trust continues this work in line with the 16 month recovery plan to

improve performance, however in May NHSI IST have withdrawn their involvement with the Trust assured that patients are being managed appropriately and safely in accordance to clinical priorities.

In the coming month trajectories are being put together to demonstrate anticipated performance against target for the remainder of the year and the interdependencies of achieving the trajectory such as consultant recruitment and sickness will be mapped to demonstrate potential impact against trajectory.

| INDICATOR | | METRIC | THRESHOLD | | ACTUALS | | | | | | | | Δ | TREND |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | | |
| Sickness Absence Rate | Sickness Absence Rate | % | ≤5% | Lower values are better | 3.6 | 5.0 | 5.1 | 5.2 | 5.8 | 5.6 | 5.5 | 5.1 | ▲ |  |

**Sickness:**

The Trust stands at 5.07% for sickness absence as at May 2019; this is a decrease to the previous month (5.48%) and evidences the continued downward trend with this metric that has been ongoing since February 2019 (5.75%).

To support the management of sickness absence across the Trust, the Terms of Reference for the Sickness Action Group have been reviewed with the purpose of the meeting re-focussed in order to be levelled towards operational performance, with each division having a representative present in order to escalate and/or highlight key hot spots to the group. Further, a divisional dashboard is in place to enable each division to outline key themes and interventions completed to enable the effectiveness (and impact) of such measures on sickness absence to be reviewed; this dashboard also encompasses the attendance management action plans that have been introduced into the HR Team to ensure consistent review/challenge to sickness absence Trust-wide.

The two yearly targets for the above group remain as 4.5% by August 2019 (in line with CQUIN target) and 4.0% by August 2020; the output of the above meeting is presented bi-monthly to the Trust Putting People First Committee. The HR teams are actively supporting line managers to ensure that individual cases are managed appropriately and that staff are supported in returning to work as soon as is appropriate.

Training is available for new and existing managers to ensure they have the skills and knowledge to effectively manage sickness absence. Further support is available from Occupational Health, particularly in guiding managers in ensuring colleagues who are returning from long term sick leave are supported in the most appropriate way. An ongoing Health & Well-being programme is accessible for staff.

**Conclusion:**

Performance improved for sickness, 52 week breaches in month 2 and the 104 day target in Month 1. Challenges continue in achieving the 62 day cancer and RTT targets. A regional approach to managing the gynae-oncology 62 day treatment target is underway with support from the Cancer Alliance. NHSI have provided great reassurance that the Trust is managing the RTT performance in the most clinically appropriate manner and are satisfied with progress made to withdraw supportive involvement to the Trust.

**APPENDIX 1**

# Board Performance Report

May 2019

# Workforce

| KPI ID | Source | Service | Target < or > | Target | Value | Trend | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Sickness Absence Rate** | **Owner - Deputy Director of Workforce** | | | | | | | | | | | | | | | | | | |
| KPI101 | NHSI | Trust | <= | 4.5% | Numerator | | 1431 | 1659 | 1613 | 1682 | 1620 | 1450 | 1917 | 2013 | 2080 | 2093 | 2278 | 2162 | 2083 |
| | | | | | Denominator | | 39700 | 38230 | 39478 | 39406 | 38270 | 39929 | 38600 | 39871 | 39868 | 36383 | 40680 | 39457 | 41042.01 |
| | | | | | Performance | | 3.61% | 4.34% | 4.09% | 4.27% | 4.23% | 3.63% | 4.97% | 5.05% | 5.22% | 5.75% | 5.60% | 5.48% | 5.07% |
| | | | | | Trend | | ▼ | ▲ | ▼ | ▲ | ▼ | ▼ | ▲ | ▲ | ▲ | ▲ | ▼ | ▼ | ▼ |
| | | | | | Target % | | 4.5% | 4.5% | 4.5% | 4.5% | 4.5% | 4.5% | 4.5% | 4.5% | 4.5% | 4.5% | 4.5% | 4.5% | 4.5% |
| | | | | | Qtrly Performance | | 4.15% | 4.15% | 4.20% | 4.20% | 4.20% | 4.54% | 4.54% | 4.54% | 5.52% | 5.52% | 5.52% | 5.27% | 5.27% |

# Efficient

| KPI ID | Source | Service | Target < or > | Target | Value | Trend | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Financial Sustainability Risk Rating: Overall Score** | | | | | **Owner - Deputy Director of Finance** | | | | | | | | | | | | | | |
| KPI087 | NHSI | Trust | <= | 3 | Performance Value | | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| | | | | | Trend | | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ |
| | | | | | Target Value | | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| | | | | | Qtrly Performance Value | | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 6 |
| **Financial Sustainability Risk Rating: Overall Score** | | | | | **Owner - Deputy Director of Finance** | | | | | | | | | | | | | | |
| KPI087 | NHSI | Trust | <= | 0 | Performance Value | | 104 | 122 | 106 | 126 | 170 | 192 | 231 | 167 | 210 | 193 | 206 | 183 | 211 |
| | | | | | Trend | | ▲ | ▲ | ▼ | ▲ | ▲ | ▲ | ▲ | ▼ | ▲ | ▼ | ▲ | ▼ | ▲ |
| | | | | | Target Value | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | Qtrly Performance Value | | 322 | 322 | 402 | 402 | 402 | 590 | 590 | 590 | 609 | 609 | 609 | 582 | 394 |

# Safety

| KPI ID | Source | Service ID | Target < or > | Target | Value | Trend | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Never Events** | **Owner - Head of Governance** | | | | | | | | | | | | | | | | | | |
| KPI181 | NHSI | Trust | = | 0 | Performance Value | | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | Trend | | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▲ | ▼ | ▶ | ▶ | ▶ | ▶ | ▶ |
| | | | | | Target Value | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | Qtrly Performance Value | | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 |
| **NHSE / NHSI Safety Alerts Outstanding** | **Owner - Head of Governance** | | | | | | | | | | | | | | | | | | |
| KPI193 | NHSI | Trust | = | 0 | Performance Value | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | Trend | | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ |
| | | | | | Target Value | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Infection Control: Clostridium Difficile** | **Owner - Infection Control Lead** | | | | | | | | | | | | | | | | | | |
| KPI104 | Quality Schedule | Trust | | 0 | Performance Value | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | Trend | | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ |
| | | | | | Target Value | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | Qtrly Performance Value | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Infection Control: MRSA** | **Owner - Infection Control Lead** | | | | | | | | | | | | | | | | | | |
| KPI105 | Quality Schedule | Trust | | 0 | Performance Value | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | Trend | | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ | ▶ |
| | | | | | Target Value | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | Qtrly Performance Value | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Neonatal Deaths (All Live Births within 28 Days) - all booked births** | **Owner - Clinical Director Neonates** | | | | | | | | | | | | | | | | | | |
| KPI168a | Trust Objectives | Neonates | <= | 4.6% | Numerator | | 2 | 1 | 1 | 0 | 3 | 2 | 3 | 1 | 1 | 2 | 1 | 1 | |
| | | | | | Denominator | | 703 | 713 | 757 | 689 | 717 | 697 | 666 | 704 | 689 | 595 | 659 | 649 | |
| | | | | | Performance | | 0.28% | 0.14% | 0.13% | 0.00% | 0.42% | 0.29% | 0.45% | 0.14% | 0.15% | 0.34% | 0.15% | 0.15% | |
| | | | | | Trend | | ▲ | ▼ | ▼ | ▼ | ▲ | ▼ | ▲ | ▼ | ▲ | ▲ | ▼ | ▲ | |
| | | | | | Target % | | 4.6% | 4.6% | 4.6% | 4.6% | 4.6% | 4.6% | 4.6% | 4.6% | 4.6% | 4.6% | 4.6% | 4.6% | 4.6% |
| | | | | | Qtrly Performance | | 0.15% | 0.15% | 0.18% | 0.18% | 0.18% | 0.29% | 0.29% | 0.29% | 0.21% | 0.21% | 0.21% | 0.15% | 0.15% |
| **Neonatal Deaths (All Live Births within 28 Days) - all live births** | **Owner - Clinical Director Neonates** | | | | | | | | | | | | | | | | | | |
| KPI168b | Trust Objectives | Neonates | <= | 6.1% | Numerator | | 3 | 2 | 1 | 0 | 4 | 2 | 3 | 1 | 1 | 2 | 1 | 1 | |
| | | | | | Denominator | | 706 | 719 | 765 | 696 | 719 | 703 | 680 | 715 | 698 | 597 | 665 | 656 | |
| | | | | | Performance | | 0.42% | 0.28% | 0.13% | 0.00% | 0.56% | 0.28% | 0.44% | 0.14% | 0.14% | 0.34% | 0.15% | 0.15% | |
| | | | | | Trend | | ▲ | ▼ | ▼ | ▼ | ▲ | ▼ | ▲ | ▼ | ▲ | ▲ | ▼ | ▲ | |
| | | | | | Target % | | 6.1% | 6.1% | 6.1% | 6.1% | 6.1% | 6.1% | 6.1% | 6.1% | 6.1% | 6.1% | 6.1% | 6.1% | 6.1% |
| | | | | | Qtrly Performance | | 0.24% | 0.24% | 0.23% | 0.23% | 0.23% | 0.29% | 0.29% | 0.29% | 0.20% | 0.20% | 0.20% | 0.15% | 0.15% |

# Effective

| KPI ID | Source | Service ID | Target < or > | Target | Value | Trend | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Intensive Care Transfers Out** | | **Owner - Clinical Director Gynaecology** | | | | | | | | | | | | | | | | | |
| KPI107 | Trust Objectives | Trust | | | Performance Value | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| | | | | | Trend | | | | | | | | | | | | | | |
| | | | | | Target Value | | | | | | | | | | | | | | |
| | | | | | Qtrly Performance Value | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 |

Liverpool Women's NHS Foundation Trust

# Experience

| KPI ID | Source | Service ID | Target < or > | Target | Value | Trend | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **18 Week RTT: Incomplete Pathways** | | **Owner - Divisional Manager Gynaecology** | | | | | | | | | | | | | | | | | |
| KPI003 | NHSI | Trust | >= | 92.0% | Numerator | | 4130 | 4238 | 4288 | 4377 | 4615 | 4523 | 4580 | 4551 | 4481 | 4626 | 4715 | 4881 | 4973 |
| | | | | | Denominator | | 4636 | 4827 | 4888 | 5059 | 5294 | 5193 | 5251 | 5298 | 5242 | 5452 | 5539 | 5769 | 5990 |
| | | | | | Performance | | 89.09% | 87.80% | 87.73% | 86.52% | 87.17% | 87.10% | 87.22% | 85.90% | 85.48% | 84.85% | 85.12% | 84.61% | 83.02% |
| | | | | | Trend | | ▼ | ▼ | ▼ | ▼ | ▲ | ▼ | ▲ | ▼ | ▼ | ▼ | ▲ | ▼ | ▼ |
| | | | | | Target % | | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% |
| | | | | | Qtrly Performance | | 88.75% | 88.75% | 87.13% | 87.13% | 87.13% | 86.74% | 86.74% | 86.74% | 85.15% | 85.15% | 85.15% | 83.80% | 83.80% |
| **18 Week RTT: Incomplete Pathway > 52 Weeks** | | **Owner - Divisional Manager Gynaecology** | | | | | | | | | | | | | | | | | |
| KPI002 | Quality Schedule | Trust | = | 0 | Performance Value | | 20 | 20 | 25 | 21 | 12 | 15 | 14 | 11 | 5 | 3 | 3 | 6 | 3 |
| | | | | | Trend | | | | | | | | | | | | | | |
| | | | | | Target Value | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | Qtrly Performance Value | | 59 | 59 | 58 | 58 | 58 | 40 | 40 | 40 | 11 | 11 | 11 | 9 | 9 |
| **18 Week RTT: Admitted Completed Pathways** | | **Owner - Divisional Manager Gynaecology** | | | | | | | | | | | | | | | | | |
| KPI001 | Trust Objectives | Trust | >= | 90.0% | Numerator | | 465 | 416 | 436 | 455 | 456 | 420 | 381 | 342 | 304 | 291 | 361 | 305 | 353 |
| | | | | | Denominator | | 513 | 447 | 469 | 525 | 526 | 497 | 471 | 390 | 403 | 355 | 409 | 348 | 397 |
| | | | | | Performance | | 90.64% | 93.06% | 92.96% | 86.67% | 86.69% | 84.51% | 80.89% | 87.69% | 75.43% | 81.97% | 88.26% | 87.64% | 88.92% |
| | | | | | Trend | | ▲ | ▲ | ▼ | ▼ | ▲ | ▼ | ▼ | ▲ | ▼ | ▲ | ▲ | ▼ | ▲ |
| | | | | | Target % | | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | | | | Qtrly Performance | | 89.60% | 89.60% | 88.62% | 88.62% | 88.62% | 84.17% | 84.17% | 84.17% | 81.92% | 81.92% | 81.92% | 88.32% | 88.32% |
| **18 Week RTT: Non-Admitted Completed Pathways** | | **Owner - Divisional Manager Gynaecology** | | | | | | | | | | | | | | | | | |
| KPI004 | Trust Objectives | Trust | >= | 95.0% | Numerator | | 1684 | 1551 | 1742 | 1354 | 1450 | 1652 | 1817 | 1208 | 1834 | 1429 | 1508 | 1441 | 1536 |
| | | | | | Denominator | | 1781 | 1687 | 1921 | 1667 | 1639 | 1830 | 2023 | 1312 | 2032 | 1576 | 1717 | 1598 | 1767 |
| | | | | | Performance | | 94.55% | 91.94% | 90.68% | 81.22% | 88.47% | 90.27% | 89.82% | 92.07% | 90.26% | 90.67% | 87.83% | 90.18% | 86.93% |
| | | | | | Trend | | ▲ | ▼ | ▼ | ▼ | ▲ | ▲ | ▼ | ▲ | ▼ | ▲ | ▼ | ▲ | ▼ |
| | | | | | Target % | | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| | | | | | Qtrly Performance | | 92.51% | 92.51% | 86.97% | 86.97% | 86.97% | 90.55% | 90.55% | 90.55% | 89.60% | 89.60% | 89.60% | 88.47% | 88.47% |
| **All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)** | | **Owner - Divisional Manager Gynaecology** | | | | | | | | | | | | | | | | | |
| KPI030 | NHSI | Gynaecology | >= | 85.0% | Numerator | | 4 | 10.5 | 8.5 | 2 | 4 | 5 | 3 | 4 | 7 | 4.5 | 5.5 | 9.5 | |
| | | | | | Denominator | | 12 | 18.5 | 17 | 7 | 11.5 | 13.5 | 13 | 5 | 12 | 9.5 | 7 | 17.5 | |
| | | | | | Performance | | 33.33% | 56.76% | 50.00% | 28.57% | 34.78% | 37.04% | 23.08% | 80.00% | 58.33% | 47.37% | 78.57% | 54.29% | |
| | | | | | Trend | | ▼ | ▲ | ▼ | ▼ | ▲ | ▲ | ▼ | ▲ | ▼ | ▼ | ▲ | ▼ | |
| | | | | | Target % | | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| | | | | | Qtrly Performance | | 46.99% | 46.99% | 40.85% | 40.85% | 40.85% | 38.10% | 38.10% | 38.10% | 59.65% | 59.65% | 59.65% | 54.29% | 54.29% |
| **Cancer: 62 Day Screening Referrals (Numbers)** | | **Owner - Divisional Manager Gynaecology** | | | | | | | | | | | | | | | | | |
| KPI033 | NHSI | Gynaecology | <= | 5 | Performance Value | | 1.0 | 0.0 | 7.0 | 1.0 | 1.0 | 2.0 | 0.5 | 2.0 | 2.0 | 1.5 | 2.0 | 0.0 | |
| | | | | | Trend | | ▲ | ▼ | ▲ | ▼ | ▶ | ▲ | ▼ | ▲ | ▶ | ▼ | ▲ | ▼ | |
| | | | | | Target Value | | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| | | | | | Qtrly Performance Value | | 1 | 1 | 9 | 9 | 9 | 4.5 | 4.5 | 4.5 | 5.5 | 5.5 | 5.5 | | 0 |
| **Cancer: 62 Day Screening Referrals (Percentage)** | | **Owner - Divisional Manager Gynaecology** | | | | | | | | | | | | | | | | | |
| KPI034 | NHSI | Gynaecology | >= | 90.0% | Numerator | | 1 | 0 | 7 | 1 | 1 | 1 | 0 | 2 | 2 | 1 | 2 | 0 | |
| | | | | | Denominator | | 1 | 0 | 7 | 1 | 1 | 2 | 0.5 | 2 | 2 | 1.5 | 2 | 0 | |
| | | | | | Performance | | | | 100.00% | | | | | | | | | | |
| | | | | | Trend | | | | | | | | | | | | | | |
| | | | | | Target % | | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | | | | Qtrly Performance | | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 66.67% | 66.67% | 66.67% | 90.91% | 90.91% | 90.91% | | |

# Experience

| KPI ID | Source | Service ID | Target < or > | Target | Value | Trend | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cancer: 104 Day Breaches** | **Owner - Divisional Manager Gynaecology** | | | | | | | | | | | | | | | | | | |
| KPI352 | Trust Objectives | Gynaecology | = | 0 | Performance Value | | 3.0 | 2.0 | 3.0 | 2.0 | 5.0 | 2.0 | 5.0 | 0.0 | 3.0 | 4.0 | 1.0 | 0.0 | |
| | | | | | Trend | | ▲ | ▼ | ▲ | ▼ | ▲ | ▼ | ▲ | ▼ | ▲ | ▲ | ▼ | ▼ | |
| | | | | | Target Value | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | Qtrly Performance Value | | 6 | 6 | 10 | 10 | 10 | 7 | 7 | 7 | 8 | 8 | 8 | | 0 |
| **A&E: Total Time Spent in department (95th Percentile)** | **Owner - Divisional Manager Gynaecology** | | | | | | | | | | | | | | | | | | |
| KPI012 | Trust Objectives | Gynaecology | <= | 240 | Performance Value | | 235 | 225 | 225 | 236 | 229 | 238 | 217 | 229 | 229 | 232 | 260 | 236 | 222 |
| | | | | | Trend | | ▲ | ▼ | ▶ | ▲ | ▼ | ▲ | ▼ | ▲ | ▶ | ▲ | ▲ | ▼ | ▼ |
| | | | | | Target Value | | 240 | 240 | 240 | 240 | 240 | 240 | 240 | 240 | 240 | 240 | 240 | 240 | 240 |
| | | | | | Qtrly Performance Value | | 690 | 690 | 690 | 690 | 690 | 684 | 684 | 684 | 721 | 721 | 721 | 458 | 458 |
| | | | | | Information Team Assured | | | | | | | | | | | | | | |
| | | | | | Metric Owner Assured | | | | | | | | | | | | | | |
| **Complaints: Number Received** | **Owner - Head of Audit, Effectiveness and Patient Experience** | | | | | | | | | | | | | | | | | | |
| KPI038 | NHSI / Quality Strate | Trust | <= | 15 | Performance Value | | 4 | 8 | 6 | 3 | 2 | 8 | 5 | 7 | 9 | 7 | 10 | 6 | 6 |
| | | | | | Trend | | ▼ | ▲ | ▼ | ▼ | ▼ | ▲ | ▼ | ▲ | ▲ | ▼ | ▲ | ▼ | ▶ |
| | | | | | Target Value | | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 |
| | | | | | Qtrly Performance Value | | 22 | 22 | 11 | 11 | 11 | 20 | 20 | 20 | 26 | 26 | 26 | 12 | 12 |
| **Friends & Family Test (Upper quartile will recommend)** | **Owner - Head of Nursing Gynaecology** | | | | | | | | | | | | | | | | | | |
| KPI089 | Quality Schedule | Trust | >= | 75.0% | Numerator | | 188 | 446 | 375 | 204 | 371 | 370 | 418 | 315 | 343 | 493 | 545 | 852 | 1128 |
| | | | | | Denominator | | 195 | 452 | 387 | 227 | 381 | 385 | 425 | 317 | 347 | 526 | 574 | 911 | 1188 |
| | | | | | Performance | | 96.41% | 98.67% | 96.90% | 89.87% | 97.38% | 96.10% | 98.35% | 99.37% | 98.85% | 93.73% | 94.95% | 93.52% | 94.95% |
| | | | | | Trend | | ▲ | ▲ | ▼ | ▼ | ▲ | ▼ | ▲ | ▲ | ▼ | ▼ | ▲ | ▼ | ▲ |
| | | | | | Target % | | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% |
| | | | | | Qtrly Performance | | 96.83% | 96.83% | 95.48% | 95.48% | 95.48% | 97.87% | 97.87% | 97.87% | 95.44% | 95.44% | 95.44% | 94.33% | 94.33% |

# APPENDIX 2

## CANCER RECOVERY PLAN

| Factor Affecting Pathway | Issue | Mitigation | Lead |
|---|---|---|---|
| **Pathology Turnaround Times** | Lengthy turnaround times of pathology reporting delaying diagnosis and treatment planning. | SLA is under review with LCL. | LWH<br>(CCG and Cancer Alliance to support as required) |
| **MRI & CT Capacity & Reporting** | Referring Trusts not completing the required imaging and referring in a timely manner delaying diagnosis. Access to additional imaging capacity for treatment planning is challenging. | Mapping of diagnostic pressures and processes regionally to support changes. | Cancer Alliance |
| **Right Diagnostic First Time** | Multiple diagnostics/appointments being completed for some patients delaying diagnosis and the treatment pathway. | Development of a One-Stop RAC model to ensure right diagnostic on first visit. | LWH & Cancer Alliance |
| **Access to Gynae-Oncologists** | Demand and capacity modelling of workforce evidences inadequate Gyane-Oncology workforce to meet the current referral demands, therefore increasing waiting times for treatment. | Business cases approved for recruiting 2 new Gynae-Oncologists. Job descriptions/plans currently being produced for RCOG approval. One ATSM started March 2019. | LWH |
| **Theatre Capacity - LWH** | Insufficient theatre capacity available to meet demand due to lack of adequate Gynae-Oncology workforce to complete treatments within target timeframe. | As above – need to recruit additional Oncologists. Job plans have been reviewed to increase capacity where able. | LWH |
| **Theatre Capacity - RLBUH** | All complex cases require theatre at RLBUH due to lack of ITU at LWH. Currently alternate week lists give insufficient capacity required to meet demand for RLBUH theatre cases and subsequent treatments target timeframes. | Negotiations underway with RLBUH for additional theatre capacity. | LWH<br>(CCG and Cancer Alliance to support as required) |
| **Late Referrals Received** | Referrals received late in pathway place additional pressure on LWH to be able to treat within target timeframes. | Monitoring late referrals and collecting trend analysis to drive changes in practice for those referring Trusts | LWH<br>(CCG and Cancer Alliance supporting) |

| Agenda Item | 2019/111 |
|---|---|

| | |
|---|---|
| **MEETING** | **Trust Board** |
| **PAPER/REPORT TITLE:** | Finance Performance Review Month 2 2019/20 |
| **DATE OF MEETING:** | Thursday, 04 July 2019 |
| **ACTION REQUIRED** | **For Assurance** |
| **EXECUTIVE DIRECTOR:** | Jenny Hannon, Director of Finance |
| **AUTHOR(S):** | Claire Scott, Head of Management Accounts<br>Eva Horgan, Deputy Director of Finance |
| | |
| **STRATEGIC OBJECTIVES:** | ***Which Objective(s)?***<br>1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐<br>2. To be ambitious and *efficient* and make the best use of available resource ☒<br>3. To deliver *safe* services ☐<br>4. To participate in high quality research and to deliver the most *effective* outcomes ☐<br>5. To deliver the best possible *experience* for patients and staff ☐ |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | ***Which condition(s)?***<br>***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐<br>***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐<br>***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒<br>***4.*** *Failure to deliver the annual financial plan ……* ☒<br>***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐<br>***6.*** *Ineffective understanding and learning following significant events……* ☐<br>***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒<br>***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ |
| **CQC DOMAIN** | ***Which Domain?***<br>***SAFE-*** *People are protected from abuse and harm* ☐<br>***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐<br>***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐<br>***RESPONSIVE –*** *the services meet people's needs.* ☐<br>***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.* ☒<br>***ALL DOMAINS*** ☐ |

| | | |
|---|---|---|
| **LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT** | **1.** Trust Constitution ☐<br>**2.** Operational Plan ☒<br>**3.** NHS Compliance ☒ | **4.** NHS Constitution ☐<br>**5.** Equality and Diversity ☐<br>***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:** | ***The Board is asked to receive assurance on the Trust's Month 2 Financial Position.*** | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee name** | Finance Performance and Business Development Committee |
| | **Date of meeting** | 24th June 2019 |
| | | |

## Executive Summary

The 2019/20 Board-approved budget is a breakeven position, after the delivery of £3.6m CIP, and receipt of £4.6m Provider Sustainability Funding (PSF), Financial Recovery Fund (FRF) and central Marginal Rate Emergency Threshold (MRET). The control total includes £0.3m of agreed investment in the costs of the clinical case for change identified in the 2019/20 operational plan, in addition to the £1.5m 2017/18 and 2018/19 investments, as well as investment in other clinical areas for safety and quality reasons.

At Month 2 the Trust is reporting a deficit of £0.6m against a deficit budget of £0.4m, giving a year to date adverse variance of £0.2m. The forecast has been maintained at the breakeven plan at this early stage in the year, although there are a number of risks against this. The key areas of financial performance are summarised below.[1]

| | Plan | Actual | Variance | RAG |
|---|---|---|---|---|
| Surplus/(Deficit) YTD | -£0.4m | -£0.6m | -£0.2m | ↓ |
| Surplus/ (Deficit) FOT | £0.0m | £0.0m | £0.0m | ↔ |
| NHSI Rating | 3 | 3 | 0 | ↔ |
| Cash | £6.8m | £7.1m | £0.3m | ↑ |
| Total CIP Achievement YTD | £0.1m | £0.1m | £0.0m | ↔ |
| Recurrent CIP Achievement YTD | £0.1m | £0.1m | £0.0m | ↔ |
| Capital Spend YTD | £3.3m | £1.8m | -£1.5m | ↑ |

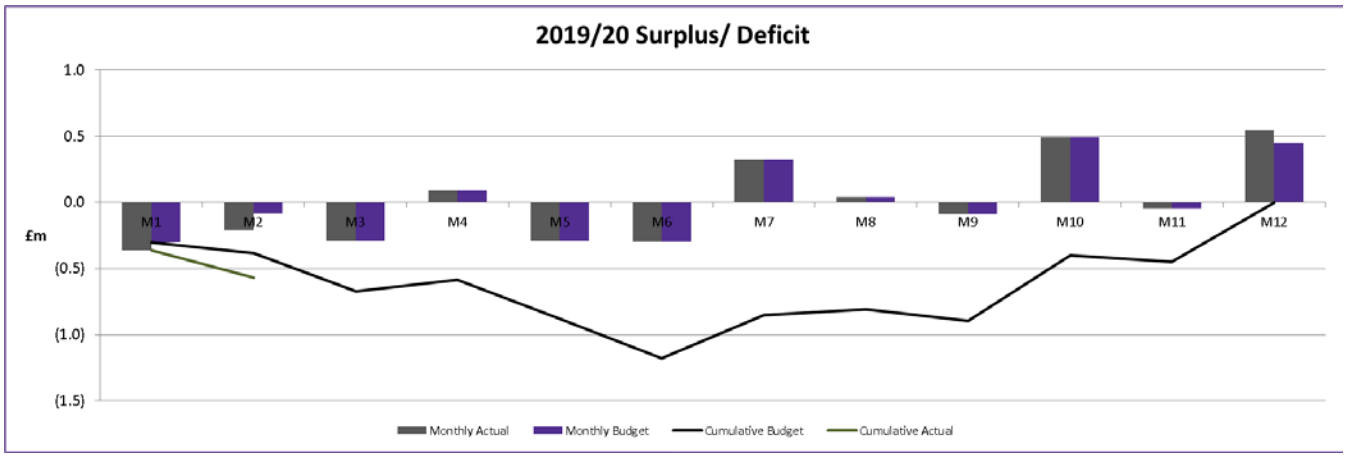
The Month 2 financial submission to NHSI is consistent with the contents of this report.

## Report

### 1. Summary Financial Position

[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.

At Month 2 the Trust is reporting a deficit of £0.6m against a deficit budget of £0.4m. The Trust is forecasting delivery of the breakeven control total, after £4.6m of central funding.




In 2019/20, a revised contractual situation is in place. Liverpool CCG, Southport & Formby CCG and South Sefton CCG remain under an "Acting as One" arrangement, although this now has a tolerance level after which a marginal payment will be made (2% to 5% under-performance; after 5% no payment is made). Knowsley CCG was part of Acting as One in 2018/19 but is no longer in 2019/20. A significant proportion of the NHS England contract is also under a block.

CIP is on track for Month 2, although note that the target was relatively low, with more schemes coming on line later in the year.

## 2. Divisional Summary Overview

Significant efforts went into an integrated planning process for 2019/20, and all budgets have been rebased. A number of cost pressures have been funded, which will be monitored through the year. There are some areas of over-spend, particularly in the Gynaecology division, but work is ongoing to rectify this position.

**Division of Family Health:** Both directorates are underspent year to date and the division is forecasting on plan for the year.

**Division of Gynaecology:** The division as a whole is overspent in Month 2 at a similar level to Month 1, at c11% of expenditure budgets (£0.4m). The position in Gynaecology directorate has worsened in Month 2 and improved in Hewitt Fertility.

In Gynaecology directorate, there continues to be a significant overspend on agency medical staffing and under performance on cost per case income. Non pay and other pay areas are largely in line with budget. There is a plan within the directorate to improve this position, a key tenet of which is the recruitment of additional medical staffing, the business case for which has now been approved.

For the Hewitt Fertility Centre, Month 2 showed marked improvement to Month 1. Overall the directorate was only marginally overspent in month, bringing the year to date overspend to £0.1m.

There are risks to delivery of the budget for the year for the division as a whole; this will be reviewed through a detailed forecast at Month 3.

**Division of Clinical Support:** The division as a whole remains marginally underspent in month and year to date.

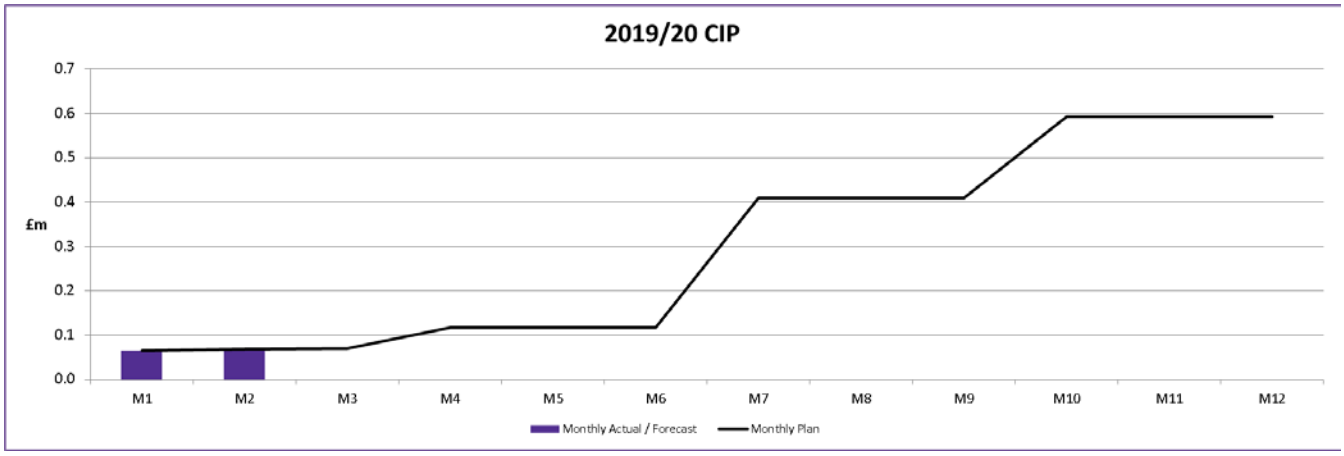
The forecast remains on plan but will be amended to reflect the position on the Genetics Labs once finalised and for the impact on Theatres and other support services on the expected increased Gynaecology activity.

**Corporate Services and Technical Items:** Overall corporate and technical items are on plan year to date, with an under achievement on income offset by an expenditure underspend, largely related to Research & Development.

**Agency:** Agency costs were significantly above budget at £0.4m year to date, and cannot continue at the current rate as the cap of £1.8m would be breached. Work is underway to address this.

## 3. CIP

At Month 2 the Trust has delivered £0.2m against the year to date target of £0.2m, and is forecasting full delivery of the £3.6m CIP on a recurrent basis. There are areas of risk, but there are also additional schemes being worked up. The 2019/20 CIP has been profiled in line with planned delivery, which shows the target increasing throughout the year as follows.




The step changes in the plan largely relate to the CNST incentive (Month 7) and the Section 106 (Month 10) schemes.

## 4. Contract Performance

Income YTD is £0.7m higher than would have been received under PbR. This is driven by both Gynaecology and Maternity, but proportionately, Gynaecology again has the most support from this arrangement. This is not unexpected, as further consultants are needed in order to deliver additional activity. Two new recruits have recently started, and a Business Case has been approved for a further four posts, so the position should improve later in the year.

| CCG | Month 2 Block | Month 2 Actual | Month 2 Variance | YTD Block Block | YTD Block Actual | YTD Block Variance | |
|---|---|---|---|---|---|---|---|
| Liverpool | 3,545 | 3,336 | -208 | 7,101 | 6,590 | -511 | -7% |
| South Sefton | 861 | 813 | -48 | 1,737 | 1,617 | -119 | -7% |
| Southport & Formby | 111 | 83 | -28 | 225 | 187 | -38 | -17% |
| **Total** | **4,516** | **4,232** | **-284** | **9,063** | **8,394** | **-668** | **-7%** |

| Service | Month 2 Block | Month 2 Actual | Month 2 Variance | YTD Block Block | YTD Block Actual | YTD Block Variance | Varaince % |
|---|---|---|---|---|---|---|---|
| Family Health (Maternity) | 2,993 | 2,827 | -165 | 5,905 | 5,559 | -346 | -6% |
| Gynaecology (Gynaecology Directorate | 1,308 | 1,266 | -41 | 2,709 | 2,498 | -211 | -8% |
| Gynaecology (Hewitt Fertility Centre) | 194 | 121 | -73 | 402 | 302 | -100 | -25% |
| Clinical Support Services | 23 | 18 | -5 | 47 | 35 | -11 | -24% |
| **Total** | **4,516** | **4,232** | **-284** | **9,063** | **8,394** | **-668** | **-7%** |

As can be seen above, performance is 7% below plan on average, but it is anticipated this will improve over the coming months.

## 5. Forecast Out-turn

At this early stage in the year, it is anticipated that the Trust will achieve its control total. A more detailed forecast will be undertaken at Month 3 and any further risks, mitigations or opportunities noted at that point. The underlying financial position will also be carefully monitored as mitigations are often non recurrent in nature and risks may be recurrent.

## 6. Cash and Borrowings

The cash position remains strong at £7.1m. This will improve further once the 2018/19 PSF is received in July or August. The Trust is anticipating repaying all its historic deficit support borrowings so this will reduce cash closer to plan. Note the capital plan is behind plan which is also assisting the cash position, but this is expected to increase over the coming months.

## 7. Capital Expenditure

Although it remains significantly (£1.5m) behind plan year to date, capital expenditure has started to increase, with spend mainly concentrated on the Neonatal redevelopment and the Global Digital Exemplar Fast Follower programmes. There are a number of additional calls on the capital plan, meaning that the contingency is likely to be largely utilised. This is monitored and agreed through the Senior Management Team meeting and the capital variation process.

## 8. BAF Risk

The BAF risk relating to delivering the financial plan was reset back to 25 at Month 1 and this score has not changed.

## 9. Conclusion & Recommendation

The Board are asked to note the Month 2 financial position and take assurance from this report.

## Appendix 1 – Board Pack

Board Finance Pack M2.xlsx

# LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

# FINANCE REPORT: M2

# YEAR ENDING 31 MARCH 2019

## Contents

**LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**
**NHS IMPROVEMENT RATIOS: M2**
**YEAR ENDING 31 MARCH 2020**

| USE OF RESOURCES RISK RATING | YEAR TO DATE Budget | YEAR TO DATE Actual | YEAR Budget | YEAR FOT |
|---|---|---|---|---|
| **CAPITAL SERVICING CAPACITY (CSC)** | | | | |
| (a) EBITDA + Interest Receivable | 734 | 600 | 6,661 | 6,661 |
| (b) PDC + Interest Payable + Loans Repaid | 317 | 332 | 7,262 | 7,262 |
| **CSC Ratio = (a) / (b)** | **2.31** | **1.81** | **0.92** | **0.92** |
| **NHSI CSC SCORE** | **2** | **2** | **4** | **4** |
| Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25 | | | | |
| **LIQUIDITY** | | | | |
| (a) Cash for Liquidity Purposes | (13,457) | (11,771) | (13,172) | (14,036) |
| (b) Expenditure | 18,878 | 18,624 | 110,554 | 110,554 |
| (c) Daily Expenditure | 309 | 305 | 303 | 303 |
| **Liquidity Ratio = (a) / (c)** | **(43.5)** | **(38.6)** | **(43.5)** | **(46.3)** |
| **NHSI LIQUIDITY SCORE** | **4** | **4** | **4** | **4** |
| Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14) | | | | |
| **I&E MARGIN** | | | | |
| Deficit (Adjusted for donations and asset disposals) | 384 | 568 | (4) | (4) |
| Total Income | (19,603) | (19,212) | (117,167) | (117,019) |
| **I&E Margin** | **-2.0%** | **-3.0%** | **0.0%** | **0.0%** |
| **NHSI I&E MARGIN SCORE** | **4** | **4** | **2** | **2** |
| Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%) | | | | |
| **I&E MARGIN VARIANCE FROM PLAN** | | | | |
| I&E Margin (Actual) | | -3.00% | | 0.00% |
| I&E Margin (Plan) | | -2.00% | | 0.00% |
| **I&E Variance Margin** | **0.00%** | **-1.00%** | **0.00%** | **0.00%** |
| **NHSI I&E MARGIN VARIANCE SCORE** | **1** | **2** | **1** | **1** |
| Ratio Score 1 = 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)% | | | | |
| **AGENCY SPEND** | | | | |
| **YTD Providers Cap** | 298 | 298 | 1,792 | 1,792 |
| **YTD Agency Expenditure** | 198 | 365 | 1,188 | 1,188 |
| | **-33.6%** | **22.5%** | **-33.7%** | **-33.7%** |
| **NHSI AGENCY SPEND SCORE** | **1** | **2** | **1** | **1** |
| Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50% | | | | |
| **Overall Use of Resources Risk Rating** | **3** | **3** | **3** | **3** |

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

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M2
YEAR ENDING 31 MARCH 2020

| INCOME & EXPENDITURE £'000 | MONTH Budget | MONTH Actual | MONTH Variance | YEAR TO DATE Budget | YEAR TO DATE Actual | YEAR TO DATE Variance | YEAR Budget | YEAR FOT | YEAR Variance |
|---|---|---|---|---|---|---|---|---|---|
| **Income** | | | | | | | | | |
| Clinical Income | (9,028) | (8,878) | (150) | (17,847) | (17,473) | (373) | (104,520) | (104,520) | 0 |
| Non-Clinical Income | (878) | (904) | 25 | (1,757) | (1,739) | (18) | (12,647) | (12,647) | 0 |
| **Total Income** | **(9,907)** | **(9,781)** | **(125)** | **(19,603)** | **(19,212)** | **(391)** | **(117,167)** | **(117,167)** | **0** |
| **Expenditure** | | | | | | | | | |
| Pay Costs | 5,979 | 5,950 | 29 | 11,962 | 11,871 | 91 | 70,862 | 70,862 | 0 |
| Non-Pay Costs | 2,282 | 2,271 | 10 | 4,578 | 4,415 | 162 | 26,628 | 26,628 | 0 |
| CNST | 1,174 | 1,174 | (0) | 2,338 | 2,338 | (0) | 13,064 | 13,064 | 0 |
| **Total Expenditure** | **9,434** | **9,395** | **39** | **18,878** | **18,624** | **254** | **110,554** | **110,554** | **0** |
| **EBITDA** | **(472)** | **(386)** | **(86)** | **(726)** | **(588)** | **(138)** | **(6,613)** | **(6,613)** | **0** |
| **Technical Items** | | | | | | | | | |
| Depreciation | 400 | 436 | (36) | 801 | 836 | (35) | 4,641 | 4,641 | 0 |
| Interest Payable | 25 | 22 | 3 | 48 | 46 | 1 | 402 | 402 | 0 |
| Interest Receivable | (4) | (7) | 2 | (8) | (12) | 3 | (48) | (48) | 0 |
| PDC Dividend | 135 | 143 | (8) | 270 | 286 | (16) | 1,617 | 1,617 | 0 |
| Profit / Loss on Disposal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Technical Items** | **555** | **594** | **(39)** | **1,110** | **1,157** | **(47)** | **6,613** | **6,613** | **0** |
| **(Surplus) / Deficit** | **83** | **208** | **(125)** | **384** | **569** | **(185)** | **(0)** | **(0)** | **0** |

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
EXPENDITURE: M2
YEAR ENDING 31 MARCH 2020

| EXPENDITURE £'000 | MONTH Budget | MONTH Actual | MONTH Variance | YEAR TO DATE Budget | YEAR TO DATE Actual | YEAR TO DATE Variance | YEAR Budget | YEAR FOT | YEAR Variance |
|---|---|---|---|---|---|---|---|---|---|
| **Pay Costs** | | | | | | | | | |
| Board, Execs & Senior Managers | 395 | 317 | 78 | 790 | 664 | 127 | 4,697 | 4,697 | 0 |
| Medical | 1,434 | 1,412 | 23 | 2,869 | 2,785 | 84 | 17,682 | 17,682 | 0 |
| Nursing & Midwifery | 2,520 | 2,567 | (47) | 5,044 | 5,112 | (68) | 30,917 | 30,917 | 0 |
| Healthcare Assistants | 411 | 412 | (2) | 821 | 838 | (17) | 4,991 | 4,991 | 0 |
| Other Clinical | 580 | 549 | 31 | 1,149 | 1,105 | 44 | 4,884 | 4,884 | 0 |
| Admin Support | 176 | 150 | 26 | 356 | 320 | 36 | 2,140 | 2,140 | 0 |
| Corporate Services | 364 | 347 | 17 | 736 | 684 | 52 | 4,370 | 4,370 | 0 |
| Agency & Locum | 98 | 196 | (98) | 197 | 363 | (166) | 1,180 | 1,180 | 0 |
| **Total Pay Costs** | **5,979** | **5,950** | **29** | **11,962** | **11,871** | **91** | **70,862** | **70,862** | **0** |
| **Non Pay Costs** | | | | | | | | | |
| Clinical Suppplies | 681 | 767 | (86) | 1,361 | 1,456 | (95) | 7,853 | 7,853 | 0 |
| Non-Clinical Supplies | 509 | 392 | 118 | 1,019 | 839 | 180 | 6,116 | 6,116 | 0 |
| CNST | 1,174 | 1,174 | (0) | 2,338 | 2,338 | (0) | 13,064 | 13,064 | 0 |
| Premises & IT Costs | 487 | 507 | (20) | 980 | 1,006 | (26) | 5,931 | 5,931 | 0 |
| Service Contracts | 604 | 606 | (1) | 1,218 | 1,115 | 103 | 6,727 | 6,727 | 0 |
| **Total Non-Pay Costs** | **3,455** | **3,445** | **10** | **6,915** | **6,753** | **162** | **39,692** | **39,692** | **0** |
| **Total Expenditure** | **9,434** | **9,395** | **39** | **18,878** | **18,624** | **254** | **110,554** | **110,554** | **0** |

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
BUDGET ANALYSIS: M2
YEAR ENDING 31 MARCH 2020

| INCOME & EXPENDITURE £'000 | MONTH Budget | MONTH Actual | MONTH Variance | YEAR TO DATE Budget | YEAR TO DATE Actual | YEAR TO DATE Variance | YEAR Budget | YEAR FOT | YEAR Variance |
|---|---|---|---|---|---|---|---|---|---|
| **Maternity** | | | | | | | | | |
| Income | (3,800) | (3,805) | 4 | (7,489) | (7,586) | 97 | (44,985) | (44,985) | 0 |
| Expenditure | 1,831 | 1,901 | (71) | 3,661 | 3,721 | (60) | 22,192 | 22,192 | 0 |
| **Total Maternity** | **(1,970)** | **(1,903)** | **(66)** | **(3,828)** | **(3,865)** | **37** | **(22,793)** | **(22,793)** | **0** |
| **Neonatal** | | | | | | | | | |
| Income | (1,439) | (1,479) | 40 | (2,833) | (2,824) | (9) | (16,972) | (16,972) | 0 |
| Expenditure | 1,080 | 1,003 | 78 | 2,161 | 2,074 | 87 | 13,041 | 13,041 | 0 |
| **Total Neonatal** | **(358)** | **(476)** | **118** | **(673)** | **(750)** | **78** | **(3,932)** | **(3,932)** | **0** |
| **Division of Family Health - Total** | **(2,328)** | **(2,380)** | **51** | **(4,500)** | **(4,615)** | **115** | **(26,725)** | **(26,725)** | **0** |
| **Gynaecology** | | | | | | | | | |
| Income | (2,179) | (2,039) | (140) | (4,458) | (4,228) | (230) | (27,996) | (27,996) | 0 |
| Expenditure | 919 | 938 | (19) | 1,842 | 1,878 | (35) | 11,444 | 11,444 | 0 |
| **Total Gynaecology** | **(1,260)** | **(1,101)** | **(159)** | **(2,615)** | **(2,350)** | **(265)** | **(16,552)** | **(16,552)** | **0** |
| **Hewitt Centre** | | | | | | | | | |
| Income | (871) | (902) | 31 | (1,767) | (1,741) | (27) | (11,108) | (11,108) | 0 |
| Expenditure | 683 | 740 | (57) | 1,366 | 1,439 | (73) | 8,130 | 8,130 | 0 |
| **Total Hewitt Centre** | **(188)** | **(162)** | **(26)** | **(402)** | **(302)** | **(100)** | **(2,978)** | **(2,978)** | **0** |
| **Division of Gynaecology - Total** | **(1,448)** | **(1,264)** | **(184)** | **(3,017)** | **(2,652)** | **(365)** | **(19,530)** | **(19,530)** | **0** |
| **Theatres** | | | | | | | | | |
| Income | (39) | (45) | 6 | (79) | (85) | 6 | (472) | (472) | 0 |
| Expenditure | 699 | 702 | (2) | 1,399 | 1,370 | 29 | 8,411 | 8,411 | 0 |
| **Total Theatres** | **660** | **656** | **4** | **1,320** | **1,285** | **35** | **7,938** | **7,938** | **0** |
| **Genetics** | | | | | | | | | |
| Income | (615) | (579) | (36) | (1,241) | (1,138) | (103) | (7,589) | (7,589) | 0 |
| Expenditure | 499 | 515 | (16) | 988 | 931 | 57 | 5,928 | 5,928 | 0 |
| **Total Genetics** | **(115)** | **(64)** | **(51)** | **(253)** | **(207)** | **(45)** | **(1,661)** | **(1,661)** | **0** |
| **Other Clinical Support** | | | | | | | | | |
| Income | (29) | (27) | (2) | (58) | (55) | (3) | (357) | (357) | 0 |
| Expenditure | 682 | 604 | 78 | 1,367 | 1,292 | 75 | 8,219 | 8,219 | 0 |
| **Total Clinical Support & CNST** | **653** | **577** | **76** | **1,309** | **1,237** | **72** | **7,862** | **7,862** | **0** |
| **Division of Clinical Support - Total** | **1,198** | **1,169** | **29** | **2,376** | **2,314** | **62** | **14,140** | **14,140** | **0** |
| **Corporate & Trust Technical Items** | | | | | | | | | |
| Income | (935) | (906) | (29) | (1,679) | (1,556) | (123) | (7,687) | (7,687) | 0 |
| Expenditure | 3,596 | 3,587 | 9 | 7,204 | 7,078 | 126 | 39,802 | 39,802 | 0 |
| **Total Corporate** | **2,661** | **2,682** | **(20)** | **5,526** | **5,522** | **3** | **32,115** | **32,115** | **(0)** |
| **(Surplus) / Deficit** | **83** | **208** | **(125)** | **384** | **569** | **(185)** | **(0)** | **(0)** | **(0)** |

**LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**
**CIP: M2**
**YEAR ENDING 31 MARCH 2020**

| NHSI SCHEME REFERENCE | SCHEME NAME | ACCOUNTING | RISK RATING | MONTH 2 TARGET | MONTH 2 ACTUAL | MONTH 2 VARIANCE | YTD TARGET | YTD ACTUAL | YTD VARIANCE | YEAR TARGET | YEAR FOT | YEAR VARIANCE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust scheme 1 | Car Parking Consumables | Non-Pay | Medium | 1 | 1 | 0 | 2 | 2 | 0 | 12 | 12 | 0 |
| Trust scheme 2 | CNST Maternity Incentive | Non-Pay | Medium | 0 | 0 | 0 | 0 | 0 | 0 | 960 | 960 | 0 |
| Trust scheme 3 | Estates Income Generation | Income | Low | 3 | 3 | 0 | 6 | 6 | 0 | 36 | 36 | 0 |
| Trust scheme 4 | Contract Savings | Pay | Low | 14 | 14 | 0 | 28 | 28 | 0 | 168 | 168 | 0 |
| Trust scheme 5 | Coding & Counting | Income | Low | 13 | 13 | 0 | 26 | 26 | 0 | 156 | 156 | 0 |
| Trust scheme 6 | Decontamination Contract | Non-Pay | Low | 3 | 3 | 0 | 6 | 6 | 0 | 36 | 36 | 0 |
| Trust scheme 7 | Meeting Utilisation | Income | Low | 1 | 0 | (1) | 1 | 0 | (1) | 11 | 11 | 0 |
| Trust scheme 8/9 | HFEA Tender | Income/Pay | Medium | 2 | 2 | 0 | 4 | 4 | 0 | 24 | 24 | 0 |
| Trust scheme 10 | HTE Contract Fees | Non-Pay | Low | 3 | 3 | 0 | 6 | 6 | 0 | 36 | 36 | 0 |
| Trust scheme 11 | Imaging Income Opportunities | Income | Low | 2 | 2 | 0 | 4 | 4 | (0) | 24 | 24 | 0 |
| Trust scheme 12 | Midwifery Productivity | Pay | Medium | 7 | 7 | 0 | 14 | 14 | 0 | 228 | 228 | 0 |
| Trust scheme 13 | Pharmacy Review | Non-Pay | Medium | 0 | 0 | 0 | 0 | 0 | 0 | 279 | 279 | 0 |
| Trust scheme 14 | Private Patient Fees | Income | Low | 0 | 0 | 0 | 0 | 0 | 0 | 198 | 198 | 0 |
| Trust scheme 15 | Procurement (various) | Non-Pay | Medium | 0 | 0 | 0 | 0 | 0 | 0 | 570 | 570 | 0 |
| Trust scheme 16 | Rateable Value Review | Non-Pay | Medium | 0 | 0 | 0 | 0 | 0 | 0 | 30 | 30 | 0 |
| Trust scheme 17 | CQC Fees | Non-Pay | Low | 7 | 7 | 0 | 14 | 14 | 0 | 84 | 84 | 0 |
| Trust scheme 18 | Restructuring | Pay | Low | 7 | 7 | 0 | 14 | 14 | 0 | 84 | 84 | 0 |
| Trust scheme 19 | Section 106 | Income | High | 0 | 0 | 0 | 0 | 0 | 0 | 501 | 501 | 0 |
| Trust scheme 20 | Job Planning | Pay | Medium | 4 | 4 | 0 | 4 | 4 | 0 | 44 | 44 | 0 |
| Trust scheme 21 | Sperm Bank | Non-Pay | High | 0 | 0 | 0 | 0 | 0 | 0 | 51 | 51 | 0 |
| Trust scheme 22 | Sutures | Non-Pay | Low | 2 | 2 | 0 | 4 | 4 | 0 | 24 | 24 | 0 |
| Mitigating Schemes | | | | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 |
| **TOTAL** | | | | **69** | **69** | **0** | **133** | **133** | **(0)** | **3,556** | **3,556** | **0** |

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M2
YEAR ENDING 31 MARCH 2020

| BALANCE SHEET £'000 | YEAR TO DATE Opening | M02 Actual | Movement |
|---|---|---|---|
| **Non Current Assets** | **79,968** | **80,730** | 762 |
| **Current Assets** | | | |
| Cash | 9,066 | 7,093 | (1,973) |
| Debtors | 7,273 | 9,911 | 2,638 |
| Inventories | 489 | 498 | 9 |
| **Total Current Assets** | **16,828** | **17,502** | **674** |
| **Liabilities** | | | |
| Creditors due < 1 year | (17,436) | (19,691) | (2,255) |
| Creditors due > 1 year | (1,654) | (1,649) | 5 |
| Loans | (13,635) | (13,635) | 0 |
| Provisions | (4,631) | (4,386) | 245 |
| **Total Liabilities** | **(37,356)** | **(39,361)** | (2,005) |
| **TOTAL ASSETS EMPLOYED** | **59,440** | **58,871** | **(569)** |
| **Taxpayers Equity** | | | |
| PDC | 40,088 | 40,088 | 0 |
| Revaluation Reserve | 14,503 | 14,503 | 0 |
| Retained Earnings | 4,849 | 4,280 | (569) |
| **TOTAL TAXPAYERS EQUITY** | **59,440** | **58,871** | **(569)** |

**LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**
**CASHFLOW STATEMENT: M2**
**YEAR ENDING 31 MARCH 2020**

| CASHFLOW STATEMENT | YEAR TO DATE | | |
|---|---|---|---|
| £'000 | Budget | Actual | Variance |
| Cash flows from operating activities | (76) | (249) | 173 |
| Depreciation and amortisation | 801 | 836 | (35) |
| Movement in working capital | (2,392) | (815) | (1,577) |
| **Net cash generated from / (used in) operations** | **(1,667)** | **(228)** | **(1,439)** |
| Interest received | 8 | 12 | (4) |
| Purchase of property, plant and equipment and intangible assets | (3,291) | (1,757) | (1,534) |
| Proceeds from sales of property, plant and equipment and intangible assets | 0 | 0 | 0 |
| **Net cash generated from/(used in) investing activities** | **(3,283)** | **(1,745)** | **(1,538)** |
| PDC Capital Programme Funding - received | 612 | 0 | 612 |
| Loans from Department of Health Capital - received | 2,138 | 0 | 2,138 |
| Loans from Department of Health Capital - repaid | 0 | 0 | 0 |
| Loans from Department of Health Revenue - received | 0 | 0 | 0 |
| Loans from Department of Health Revenue - repaid | 0 | 0 | 0 |
| Interest paid | 0 | 0 | 0 |
| PDC dividend (paid)/refunded | 0 | 0 | 0 |
| **Net cash generated from/(used in) financing activities** | **2,750** | **0** | **2,750** |
| **Increase/(decrease) in cash and cash equivalents** | **(2,200)** | **(1,973)** | **(227)** |
| **Cash and cash equivalents at start of period** | 9,000 | 9,066 | (66) |
| **Cash and cash equivalents at end of period** | **6,800** | **7,093** | **(293)** |

| LOANS SUMMARY<br>£'000 | Loan Principal Drawndown | Loan Principal Repaid | Loan Principal Outstanding at M2 |
|---|---|---|---|
| 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: M2
YEAR ENDING 31 MARCH 2020

| CAPITAL EXPENDITURE<br>£'000 | Year to Date Budget | Year to Date Actual | Year to Date Variance |
|---|---|---|---|
| Neonatal New Building | 2,138 | 1,505 | 633 |
| Estates Schemes | 160 | 21 | 139 |
| Global Digital Examplar Fast Follower Project | 198 | 228 | (30) |
| Medical Equipment | 373 | 11 | 362 |
| IT Schemes | 424 | 0 | 424 |
| **Total** | **3,293** | **1,765** | **1,528** |

**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 | 2019/112 |
|---|---|

| | |
|---|---|
| **MEETING** | **Board of Directors** |
| **PAPER/REPORT TITLE:** | **Board Assurance Framework** |
| **DATE OF MEETING:** | Thursday, 04 July 2019 |
| **ACTION REQUIRED** | **For Assurance** |
| **EXECUTIVE DIRECTOR:** | Colin Reid, Trust Secretary |
| **AUTHOR(S):** | Christopher Lube, Head of Governance and Quality |
| | |
| **STRATEGIC OBJECTIVES:** | ***Which Objective(s)?***<br>1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐<br>2. To be ambitious and *efficient* and make the best use of available resource ☒<br>3. To deliver *safe* services ☒<br>4. To participate in high quality research and to deliver the most *effective* Outcomes ☐<br>5. To deliver the best possible *experience* for patients and staff ☒ |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | ***Which condition(s)?***<br>***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒<br>***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒<br>***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒<br>***4.*** *Failure to deliver the annual financial plan ……* ☒<br>***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒<br>***6.*** *Ineffective understanding and learning following significant events……* ☒<br>***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒<br>***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒ |
| **CQC DOMAIN** | ***Which Domain?***<br>***SAFE-*** *People are protected from abuse and harm* ☐<br>***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐<br>***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐<br>***RESPONSIVE –*** *the services meet people's needs.* ☐<br>***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.* ☐<br>***ALL DOMAINS*** ☒ |

| | | |
|---|---|---|
| **LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT** | **1.** Trust Constitution ☒<br>**2.** Operational Plan ☒<br>**3.** NHS Compliance ☒ | **4.** NHS Constitution ☒<br>**5.** Equality and Diversity ☒<br>***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 Board Assurance Framework and confirm that the Board Assurance Framework assurance adequately identify the principal risks to achieving the Trust's strategic objectives. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee name** | The Committees of:<br>Finance, Performance and Business Development,<br>Putting People First<br>Quality Committee |
| | **Date of meeting** | 24 June 2019 |
| | | |

**Executive Summary**

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

The BAF is based on based on seven key elements:

- Clearly defined Key Priorities for 2019/20 (aligned to the Trust Strategic Aims)
- Clearly defined principle risks to the key priorities together with an assessment of their potential impact and likelihood.
- Key controls by which the risk can be managed.
- Potential and positive assurance that risk are being appropriately managed.
- Board reports detailing how risk are being managed and objectives met, together with the identification of gaps in assurances and gaps in control.
- Risk mitigation plans, for each risk, which ensures the delivery of the objectives, control of risk and improvements in assurances.
- A target risk rating.

**Process:** The Head of Governance and Quality meets with each of the Executive Director leads on a monthly basis to ensure the BAF is maintained and updated as a live document.

Each committee of the Board which has accountability for the risks on the BAF, reviews the BAF at its meetings to receive assurance that the risks continue to be managed appropriately and that controls and mitigations are in place to reduce the impact of the risk on the Trust.

## Report

### 1. Introduction

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

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

**BAF Risks – June 2019:**

Trust BAF June 2019 v1.5 (Post Comms).d

### 2. Board Committee – Proposed amendments to the BAF

Since the last report to the Board, the Board committees reviewed the risks within their remit and no amendments have been made to the BAF.

### 3. New Risks and Closed Risk

No new risks or closed risk have been recommended by the Board Committees since the last report.

### 4. Conclusions

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

**The Board are asked to:**

The Board is asked to receive the Board Assurance Framework and confirm that the Board Assurance Framework assurance adequately identify the principal risks to achieving the Trust's strategic objectives.

# 2019/20 Live Board Assurance Framework – June 2019 – Version 1.5

**Strategic Objective:** To develop a well led, capable, motivated and entrepreneurial workforce

**Risk Appetite:** Moderate

**Objective:** To deliver a well-led, engaged, motivated and effective workforce

**CQC Domain:** Well-Led

**Enabling Strategy:** Putting People First Strategy

**Executive Lead:** Michelle Turner

**Operational Lead:** Jeanette Chalk

**Assurance Committee:** Putting People First (PPF)

| Risks to objective | Controls | Gaps in controls | Sources of assurance | Assurance outcomes / gaps | Action plan | Timescales |
|---|---|---|---|---|---|---|
| **Principal Risks - 1744**<br><br>**Condition:** Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust<br><br>**Cause:** Poor staff morale, lack of clarity around objectives, lack of ability to influence in the workplace, lack of organisational/job security, lack of leadership, behaviour contrary to the trust values<br><br>**Consequence:** Failure to deliver high quality, safe patient care, impact on recruitment & retention, failure to achieve strategic vision, potential for regulatory action and reputational damage | • Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff<br>• Consultant revalidation process<br>• Reward and recognition processes linked to values<br>• Retirement Intentions annual exercise<br>• Pay progression linked to appraisal and mandatory training compliance.<br>• Targeted OD intervention for areas in need of support<br>• Management Development Training Programme<br>• Aspirant Talent Programme for aspiring ward managers and matrons<br>• Programme of health and wellbeing initiatives<br>• All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities.<br>• Extensive mandatory training programme available<br>• Value-based recruitment & induction<br>• Workforce planning processes in place to deliver safe staffing<br>• Investment in engagement tool (2018)<br>• Shared decision making with JLNC & Partnership Forum<br>• Putting People First Strategy<br>• Quality Strategy 2017-2020<br>• Staff engagement programmes<br>• Two Freedom to Speak Up<br>• Whistleblowing Policy<br>• Guardian of Safe Working<br>• Engagement tool implemented<br>• People Strategy revised and agreed | • Quality of appraisal<br>• Poor attendance at non-mandatory training eg. leadership training<br>• Requirement for further development middle managers<br>• Talent management programme is newly implemented and not yet fully embedded<br>• Ongoing challenges of engaging effectively with all staffing groups due to rota patterns | **Management assurance**<br>• National Staff surrey (annual)<br>• Quarterly internal staff survey (Go Engage System)<br>• Monthly KPI's for controls<br>• Performance Reports (monthly)<br>• Quarterly Learning Events<br>• Bi-annual Speak up Guardian Reports<br>• Report form Guardian of Safe Working<br><br>**Metrics**<br>• Increase in managers attending training programme<br>• Mandatory training data<br>• Absence data<br>• Turnover data<br>• Whistleblowing data<br>• Staff Engagement Score<br>• Sickness data<br>• Guardian for Safe Working Exception Reports | **Assurance Gaps**<br>• None at this time | • PPF deep dive into service workforce risks<br>• Aspirant Managers programme being rolled out<br>• Executive Team and staff side walkabouts<br>• Launch of Fair and Just Culture Project | • Monthly monitoring<br>• Monthly monitoring 2019<br>• Monthly monitoring 2019<br>• April 19 (revised date) |
| **Risks from Risk Register**<br>• 1704 – Risk of staff not completing mandatory training<br>• 1690 – Risk of staff not having an annual appraisal<br>• 428- Risk of pre-employment screen not being completed appropriately<br>• 2264 – Risk of maternity staff not completing clinical mandatory training | | | **Independent / semi-independent**<br>• POPPY study<br>• RCM culture survey findings due Q1/2 2018<br>• CQC regulatory inspection in 2018<br>• National Workforce and Wellbeing Charter -2018 | **Outcome Gaps**<br>• Staff Survey Engagement score not improved in year<br>• Mandatory training currently below target<br>• PDR compliance currently below target<br>• Sickness absence above target | | |



| Inherent risk level | | | Current risk level | | | Target risk position by 31.3.20 | | |
|---|---|---|---|---|---|---|---|---|
| Likelihood | Impact | Score | Likelihood | Impact | Score | Likelihood | Impact | Score |
| 5 | 5 | **25** | 2 | 5 | **10** | 2 | 5 | **10** |

**Strategic Objective:** To develop a well led, capable, motivated and entrepreneurial workforce
**Risk Appetite:** Moderate

**Objective:** Fully Resourced, Competent & Capable Clinical Workforce **(Revised Risk)** **CQC Domain:** Well-Led **Enabling Strategy:** Putting People First Strategy

**Executive Lead:** Michelle Turner **Operational Lead:** Jeanette Chalk **Assurance Committee:** Putting People First (PPF)

| Risks to objective | Controls | Gaps in controls | Sources of assurance | Assurance outcomes / gaps | Action plan | Timescales |
|---|---|---|---|---|---|---|
| **Principal Risks – TBC**<br><br>**Condition:**<br>Insufficient numbers of clinical staff resulting in a lack of capability and capacity to deliver safe care and effective outcomes<br><br>**Cause:**<br>Insufficient numbers of doctors in training<br>Ageing nursing workforce<br>National shortage of nurses & midwives<br>Isolated site & associated clinical risk impacting on the recruitment and retention of specialist Consultant staff<br>Pension Tax changes impacting on the retention of consultant medical staff (early retirement or reduction in working time)<br><br>**Consequence**<br>Gaps on junior doctor rotas<br>Loss of highly experienced nursing staff due to retirement<br>Impact on the quality of junior doctors training<br>May result in unsafe patient care and less effective outcomes<br>May impact on status as a teaching hospital<br>May impact on retention of specialist services | • Annually agreed funding contract with HEN<br>• Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer.<br>• Lead Employer notifies the Trust of gaps in local rotations, giving the Trust autonomy to recruit at a local level in to these gaps.<br>• Effective electronic rota management system implemented .<br>• Director of Medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN<br>• Guardian of Safe Working Hours appointed in 2016 under new Junior Doctor Contract (2016).<br>• Acting-down policy and process in place to cover junior doctor gaps<br>• National Revalidation process ensuring competent staff<br>• Shared decision making and review of risks with Joint Local Negotiating Committee<br>• Putting People First Strategy<br>• Quality Strategy 2017-2020<br>• Strategic Workforce Group established<br>• GMC Survey 2018 action plan in place<br>• Aspirational Ward Manager Programme<br>• Succession Planning and Talent Programme<br>• NHSE Retention Improvement Programme<br>• NHSI Sickness Improvement Programme | • Further utilisation of the rota management system<br>• E-Rostering System not fully utilised | **Management assurance**<br>• Quarterly reporting by Guardian of Safe<br>• DME reports to HEN on an annual basis in relation to junior doctor training<br>• Annual GMC Survey<br>• Strategic Workforce reporting to PPF<br>• Annual Staff Survey<br>• Safer Staffing Report Bi-Annually<br>• NHS Ed SAR<br>• DME Annual Report<br>• Leadership Development Programme Review (Annual at PPF)<br>• Exception Reporting system and process working effectively<br><br>**Metrics**<br>• Exception reporting data<br>• Monitoring exercise data<br>• Absence data from Lead Employer<br>• Whistleblowing reports<br><br>**Independent / semi-independent**<br>• GMC Revalidation process.<br>• HEN visit – regular (next due 2019 due to satisfactory report in 2016).<br>• GMC Medical Staff survey - annual | **Assurance Outcomes**<br>• Junior Medical Staff GMC survey reporting to Education Governance & PPF – no areas of specific concern identified<br><br>• Clinical & nursing roles being developed and enhanced to mitigate the gaps in the junior doctor workforce. Roles include; Physician Assistants, Surgical Assistants, ANP's, Consultant Nurses, ER Practitioners.<br><br>**Assurance Gaps**<br>• None Identified<br><br>**Outcome Gaps**<br>None identified at this time | • Action plan from Strategic Group<br><br>• DDN undertaking E-Rostering utilisation challenge, report to Divisional Data Meetings<br><br>• Business care to go to NHSI to develop E-Rostering System, Collaborative work with CMHRD Network | • Monthly monitoring<br><br>• Sept 2019<br><br>• June 2019 |
| **Risks from Corporate Risk Register**<br>• 2090 Neonatal Service Staffing<br>• 2244 Resuscitation Training officers<br>• 2087INsuffcient obstetric Consultant Cover<br>• 1953 Insufficient Jr Dr Cover<br>• 1709 Insufficient consultant and senior medical cover | | | | | | |



| Inherent risk level | | | Current risk level | | | Target risk position by 31.3.2 | | |
|---|---|---|---|---|---|---|---|---|
| Likelihood | Impact | Score | Likelihood | Impact | Score | Likelihood | Impact | Score |
| 5 | 5 | **25** | 4 | 5 | **20** | 2 | 5 | **10** |

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

**Objective:** Long-term financial sustainability

**CQC Domain:** Well-Led / Effective

**Enabling Strategy:** Strategic Options Appraisal

**Executive Lead:** Jenny Hannon

**Operational Lead:** Eva Horgan

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

| Risks to objective | Controls | Gaps in controls | Sources of assurance | Assurance outcomes / gaps | Action plan | Timescales |
|---|---|---|---|---|---|---|
| **Principal Risks - 1986**<br><br>**Condition:** The Trust is not financially sustainable beyond the current financial year<br><br>**Cause:**<br>• Ongoing requirement for annual CIPs (inc delivery of EPR)<br>• Significant CNST premium<br>• Overhead costs<br><br>**Consequence:** Lack of financial stability, invocation of NHSI sanctions, special measures. Continued borrowing to meet operational expenses resulting in significant debt. | • 5 year financial model produced giving early indication of issues<br>• Business case to Trust Board which identified a solution which minimised deficit, including relocation to an acute site and merger<br>• Early and continuing dialogue with NHS Improvement and NHS England<br>• Active engagement with CCG through the Healthy Liverpool Programme and Women and Neonatal Oversight Board, resulting in a Pre Consultation Business Case<br>• Agreement for merger proposals with partner Trusts approved by three BoDs<br>• Advisors with relevant experience (PWC) engaged early to review strategic options<br>• Clinical engagement and support for proposals<br>• Review of open claims and legal processes<br>• Engagement in place with Cheshire and Mersey Partnership to review system solutions | • Implementation of business case is dependent on decision making external to the trust (CCG, NHSI, NHSE)<br>• Uncertainty regarding availability of capital funding necessary to implement business case<br>• Establishment of governance procedures to manage the merger transaction<br>• Merger dependent on external partners | **Management assurance**<br>•5 year plan approval (BoD – Nov 2014) resubmission due Summer 2019.<br>•Future Generations Clinical Strategy and Business Plan (BoD Nov15)<br>•Sustainability & Transformation Plan (FPBD – Jul' 16)<br>•PCBC Approval (FPBD – Oct' 16)<br>•Strategic Outline Case for merger approved by three Trust Boards (BoD Jun 16)<br>•SOC for preferred option proved by Board – Sep 17<br>•Submission of Cheshire and Mersey STP capital bid Summer 2018 ranked No1 | **Gaps**<br>• Final approval for business case<br>• Lack of capital nationally | • Revision of SOC following unsuccessful STP capital bid.<br><br>• Clinical Summit to review and update clinical risk and outcomes.<br><br>• Approval of revised capital route.<br><br>• Public consultation by CCG following development of preferred option<br><br>• Further discussion with key stakeholders following outcome of consultation exercise<br><br>• Decision making business case produced by CCG and final decision following outcome of public consultation<br><br>• Business Case to support the application for capital to support the relocation<br><br>• Merger transaction<br><br>• Implementation of changes | • June 2019<br><br>• June 2019<br><br>• November 2019<br><br>• April 2020 (subject to approval of capital bid.<br><br>• July<br><br>• December 2020<br><br>• TBC –requirement to be confirmed subject to outcome of bid<br><br>• April 2021 (subject to NHSI approval)<br><br>• April 2021-2026 |
| **Risks from Risk Register**<br>• 2128 - Risk that the uncertainty regarding the future of the Trust's services<br>• 597 - Risk of fraud and error if internal controls are not followed | | | **Metrics**<br>• Monthly formal data submission<br>• Long term financial projections<br><br>**Independent / semi-independent**<br>• CCG Pre Consultation Business Case, approved by CCG Committees in Common<br>• Northern Clinical Senate Report supporting preferred option<br>• Cheshire and Mersey Partnership support | **Outcomes**<br>• Delivery of a surplus<br>• NHS I use of resources rating above 2 over a five year time period<br>• Clinical Senate Report – Sept 17<br>• Reduction in CNST Premium<br>• Reduction in back office overhead costs | | |



| Inherent risk level | | | Current risk level | | | Target risk position by 31.3.20 | | |
|---|---|---|---|---|---|---|---|---|
| Likelihood | Impact | Score | Likelihood | Impact | Score | Likelihood | Impact | Score |
| 5 | 5 | **25** | 5 | 5 | **25** | 5 | 5 | **25** |

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

**Risk Appetite: Moderate**

**Objective:** Deliver the annual financial plan

**CQC Domain:** Well-Led / Effective

**Enabling Strategy:** Operational Plan

**Executive Lead:** Jenny Hannon

**Operational Lead:** Eva Horgan

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

| Risks to objective | Controls | Gaps in controls | Sources of assurance | Assurance outcomes / gaps | Action plan | Timescales |
|---|---|---|---|---|---|---|
| **Principal Risks - 2168**<br><br>**Condition:** Failure to deliver the annual financial plan<br><br>**Cause:**<br>• Slippage against CIP targets (inc EPR delivery and CNST contribution reduction)<br>• Hewitt Fertility Centre loss of patient numbers resulting in reduced contribution<br>• Increases in patient activity as contracts are largely on a block basis<br>• Workforce cost pressures<br>• Pressure to deliver national targets<br><br>**Consequence:** Breach of license conditions resulting in financial special measures | • Robust budget setting process<br>• Quality Impact Assessments of all CIPs and post evaluation reviews<br>• Sign off of budgets by accountable officers<br>• FPBD & Board approval of budgets<br>• Budget holder training programme in place<br>• Monthly reporting to all budget holders with variance analysis<br>• Monthly reporting to FPBD & Trust Board<br>• Monthly reporting to and feedback from NHS Improvement<br>• Internal audit reviews of systems and controls<br>• Vacancy control process well established and monitored<br>• Control of expenditure through actively monitoring spends<br>• Monthly performance meetings | • Lack of contingency in budgets | **Management assurance**<br>•2019/20 budget approval (BoD – April 2019)<br>•Budget holder training manual and attendance records<br>•Performance & Finance Report (monthly to FPBD and BoD)<br>•Finance & CIP achievement (monthly to FPBD)<br>•Executive Team & Board oversight<br>•Internal audit report provides significant assurance (Oct 17)<br>•Sustained performance above plan<br>•Delivery of Control Total in previous years | **Gaps**<br>• Assurance is available re: controls but not on delivery | • Ongoing review of position in divisional performance meetings and finance committee<br><br>• Quality performance challenge meetings<br><br>• Ongoing review of CIP<br><br>• Monthly budget meeting with variance analysis. | Monthly monitoring |
| **Risks from Risk Register**<br>• 1663 – Operational grip on the creation and delivery of a financially sustainable plan (Corporate Risk) | | | **Metrics**<br>•Monthly financial data<br><br>**Independent / semi-independent**<br>• Monthly reports to NHSI with feedback<br>• Internal audit review of budgetary controls<br>• External audit opinion<br>• | **Outcomes**<br>• Delivery of control total in 19/20<br>• Delivery of £3.6m CIP for 19/20<br>• NHS I Use of Resources Risk Rating – 3 | | |



| Inherent risk level | | | Current risk level | | | Target risk position by 31.3.20 | | |
|---|---|---|---|---|---|---|---|---|
| Likelihood | Impact | Score | Likelihood | Impact | Score | Likelihood | Impact | Score |
| 5 | 5 | **25** | 5 | 5 | **25** | 2 | 5 | **10** |

**Strategic Objective:** To deliver **safe** services
**Risk Appetite:** Low

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

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

| Risks to objective | Controls | Gaps in controls | Sources of assurance | Assurance outcomes / gaps | Action plan | Timescales |
|---|---|---|---|---|---|---|
| **Principal Risks - 1986**<br><br>**Condition:** Location, size, layout and accessibility of current services do not provide for sustainable integrated care or safe and high quality service provision.<br><br>**Cause:** Lack of onsite multidisciplinary provision, no ITU or blood bank on site, very limited diagnostic imaging on site. Failure to meet multiple clinical standards. Senior staff recruitment and retention very difficult, lack of collocated paediatric surgical support.<br><br>**Consequence:** Patient harm, poor continuity of care, poor patient experience due to transfer away from booking location<br><br>**Risks from Risk Register**<br>• 1819- Risk of delays in treatment and diagnosis due to LWH on single site (Gynaecology)<br>• 1827 – Risk of sub-optimal care due to LWH being on single site (Maternity)<br>• 2086- Inadequate provision of on site blood bank | • Early and continuing dialogue with regulators<br>• Active engagement with CCGs<br>• Putting People First Strategy<br>• Environmental risk assessments<br>• Leadership & Management Development Programme<br>• Programme for the establishment of single service for Neonates with AHCH<br>**Adult Services**<br>• Longstanding/historical support for RLBUHT and AUH senior ) medical and Surgical) clinicians to provide acute/elective support when required.<br>• Attendance of RLBUHT to LWH site in acute case or need.<br>• Abilities to transfer acutely ill patient to RLBUHT for care<br>• Access to RLBUHT for diagnostic services such as imaging.<br>• Blood product provision by motorised vehicle from near by facility.<br>• Well established methods for detecting deterioration in patients and arranging escalation/transfer.<br>• Access to RLBHT for surgery for women with advanced pelvic cancers and severe co-morbidities.<br>**Neonatal Services**<br>• Early detection of neonates with deteriorating condition<br>• Close contacts with AHCH paediatric surgeons<br>• Transfer arrangements well established. | • STP submission for capital bid complete din Nov 2018 – not successful<br><br>• Clinical case for change is dependent on decision making external to the trust (CCG, NHSI, NHSE)<br><br>• Financial constraints for delivery of facilities improvements on site<br><br>• Development of Crown Street site impracticable in relation to imaging, ITU a blood bank and staffing unlikely to be achievable | **Management assurance**<br>•Corporate Objectives 2018-19<br>•Board Performance Reports<br>•DIPC Reports<br>•Staffing Reports to Board<br>•Incident and SI reports to Safety Senate and Board<br><br>**Metrics**<br>•Performance monitoring of patient experience and clinical outcomes<br>•Incident Data (including SIs / Never Events)<br>•Safe staffing levels<br>•Transfers out<br>•Data reviewed regularly and reported through HDU group<br><br>**Independent / semi-independent**<br>• CQC Inspection (2018)<br>• Review of fire provision<br>• Vanguard review of Maternity Base<br>• Neonatal ODM<br>• Maternity SCN Dashboard<br>• Clinical senate report<br>• NICU SOC<br>• Neonatal peer review Jan 18 | **Gaps**<br>• Gaps in fire provision ( SLA with Aintree estates in place, review completed and risks assessed with generation of priorities presented to Exec Dir ) – Jan 18)<br><br>**Outcomes**<br>• Failure to meet BAPM standards<br>• Non-compliance of HBN accommodation standards on Neonatal Unit<br>• Consultant presence on Delivery Suite<br>• Transfers of complex cancer patients<br>• Failure to meet RCOA Standards for Care of Women Critically Ill and Women in Childbirth, August 2018. | • Commence public consultation<br><br>• Agree a business case for a new build<br><br>• Re -Submission of capital bid<br><br>• Await and review outcome of clinical summit (June 2019)<br><br>• Divisional plans to be developed to support long term clinical sustainability<br><br>**Long term**<br><br>• Clinical engagement in case for change through Future Generations Strategy and PCBC | • Monthly monitoring ( NHSE lead)<br><br>• Monthly monitoring (external lead)<br><br>• December 2019<br><br>• July 2019<br><br>• December 2019 |



| Inherent risk level | | | Current risk level | | | Target risk position by 31.3.20 | | |
|---|---|---|---|---|---|---|---|---|
| Likelihood | Impact | Score | Likelihood | Impact | Score | Likelihood | Impact | Score |
| 5 | 5 | **25** | 4 | 5 | **20** | 4 | 5 | 20 |

**Strategic Objective:** To deliver **safe** services
**Risk Appetite:** Low

**Objective:** Learning from events | **CQC Domain:** Safe | **Enabling Strategy:** Risk Management Strategy

**Executive Lead:** Andrew Loughney | **Operational Lead:** Christopher Lube | **Assurance Committee:** Quality Committee (QC)

| Risks to objective | Controls | Gaps in controls | Sources of assurance | Assurance outcomes / gaps | Action plan | Timescales |
|---|---|---|---|---|---|---|
| **Principal Risks - 1742**<br><br>**Condition:** Ineffective understanding and learning following significant events<br><br>**Cause:** Failure to identify root cause, system structures and process, failure to analyse thematically, failure to respond proportionately<br><br>**Consequence:** Patient harm, failure to learn and improve the quality of service and experience, poor quality services, loss of income and activity, reputational damage, increased staff turnover | • Regular dialogue with regulators and CCGs<br>• Incident reporting and investigation policies and procedures.<br>• MDT involvement in safety projects<br>• HR policies in relation to issues relating to professional and personal responsibility.<br>• Mandatory training in relation to safety and risk.<br>• Staffing level acuity exercises<br>• Scoping for relevant national reports<br>• Quality Strategy 3 yr programme in progress<br>• Risk Management Strategy<br>• Governance structure<br>• Serious Incident Feedback Form<br>• Serious Incident Panels<br>• Corporate level engagement by board<br>• Listening events<br>• Never events reported through Safety Senate and BoD<br>• 2nd year of Quality Strategy Delivered<br>• Patient safety included in executive and NED walk rounds. | • Inconsistent completion and dissemination of actions and improvement plans.<br>• Inconsistent implementation of lessons learnt and lack of evidence<br>• Pace of implementing change<br>• Lack of opportunity to deliver bespoke training for staff groups in relation to risk management and patient safety.<br>• Human Factors Training and simulation not constantly available to all staff groups | **Management assurance**<br>• CQPG Meetings<br>• Reporting of incidents and management of action plans through Safety Senate<br>• Reflection of risks and Cooperate Risk Register and Board Assurance Framework<br>• CQC Assessment<br>• Annual Quality Account Report | **Gaps**<br>• Inconsistent use of benchmarking tools<br>• Difficult to gain consistent assurance that clinicians are following best practice<br>• Some national audits / studies do not provide benchmarking of data, if they do this is in an inconsistent format making it difficult to accurately assess and compare trust status.<br>• Lack of testing of action plans following audits to ensure they lead to embedded change.<br>• External and internal reporting structures | • Develop better reporting from the Ulysses System.<br><br>• New divisional structures to review implementation of lessons learnt and provision of evidence.<br><br>• Divisions to undertake gap analysis of risk management resources<br><br>• Business case for the provision of Huma Factors Training to be developed and submitted to Education Governance Committee<br><br>• Head of Governance to develop risk management and patient safety training package<br><br>• Fair and Just culture Project<br><br>• Maintain close involvement with regional and local safety collaborative | • October 19<br><br>• September 19<br><br>• September 19<br><br>• August 19<br><br>• September 19<br><br>• October 19 (Revised Date)<br><br>• Monthly monitoring (revised date) |
| **Risks from Risk Register**<br>• 1734 Risk of repeat incidents leading to costly events (Corporate Risk)<br>• 1966 – Risk of safety incident form Invasive procedures | | | **Metrics**<br>• Safe domain performance metrics<br>• Incident reporting<br>• Levels of patient harm<br>• Quarter reports to CCG<br>• Benchmarking through VON, EMBRACE<br><br>**Independent / semi-independent**<br>• Internal audit of Risk Management (Oct-16)<br>• External audit of risk maturity by Gorisa Ltd (Nov-16)<br>• CQC assessment form 2018 visit Safe as 'Good' across all areas of the Trust<br>• NRLS Incident Reporting Report<br>• MIAA report on Duty of Candour<br>• Safety Senate Reports | **Outcomes**<br>• CQC assessment from 2018 visit Safe as 'Good' across all areas of the Trust | | |



| Inherent risk level | | | Current risk level | | | Target risk position by 31.3.20 | | |
|---|---|---|---|---|---|---|---|---|
| Likelihood | Impact | Score | Likelihood | Impact | Score | Likelihood | Impact | Score |
| 5 | 4 | **20** | 3 | 4 | **12** | 2 | 3 | **6** |

**Strategic Objective:** To deliver **safe** services

**Risk Appetite:** LOW

**Objective:** Regulatory compliance | **CQC Domain:** Safe / Well-Led | **Enabling Strategy:** Risk Management Strategy

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

| Risks to objective | Controls | Gaps in controls | Sources of assurance | Assurance outcomes / gaps | Action plan | Timescales |
|---|---|---|---|---|---|---|
| **Principal Risks - 1739**<br><br>**Condition:** Inability to achieve and maintain regulatory compliance, performance and assurance<br><br>**Cause:** Lack of robust processes and management systems to provide evidence and assurance to regulatory agencies<br><br>**Consequence:** Enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services | • Regular meetings with NHSE/I<br>• CQC engagement meetings<br>• Maintenance of CQC registration<br>• Regulatory information provided to staff at Induction<br>• Committee structures in place to monitor regulatory compliance.<br>• Board assurance visits.<br>• NED Walk rounds<br>• An integrated approach between corporate, operational and governance teams.<br>• Quality Impact Assessments for all service changes and CIPs that are considered<br>• Professional standards<br>• Trust policies and procedures<br>• Risk Management Strategy and culture<br>• National audits<br>• Local audits<br>• Ward accreditation scheme pilot being carried out during April<br>• Quality and independence of QIA's by DoN and MD<br>• External peer reviews<br>• Completion and Submission of Annual Quality Report<br>♣ H&S Executive Inspections<br>♣ Human Tissue and Embryology Authority (HFEA) Inspections | • Benchmarking data can make the trust appear an outlier due to the specialist nature of the services provided and attract regulatory attention | **Management assurance**<br>• MIAA Audit<br>• CQC Visit<br>• CCG Meetings monthly<br>• Executive walk rounds<br>• Matron walk rounds<br>• Ward Accreditation<br>• Internal H&S walk rounds and annul audits<br>• Internal Fires Safety Inspections | **Gaps**<br>♣ Monitoring of regulatory reports and actions plans to completion | • Provide assurance to CQC in relation to risks with appropriate information.<br>• Roll out of Ward Accreditation following pilot completion.<br>• Embed process for monitoring of regulatory reports and action plans into new Division.<br>• Report regulatory exceptions from Divisions to Quality Committee<br>• Undertake intermittent deep dives reviews into specialist services | • Ongoing<br>♣ Sept 19<br>♣ Sept 19<br>♣ Monthly<br>♣ As required |
| **Risks from Risk Register**<br>• 1736 Business Continuity (Corporate Risk)<br>• 2074 Fire Regulations (Corporate Risk)<br>• 1734 Risk of repeat incidents leading to costly events (Corporate Risk)<br>• 1966 Risk of safety incidents (Corporate Risk) | | | **Metrics**<br>• Internal audit metrics<br>• High level performance metrics<br><br>**Independent / semi-independent**<br>• CQC Inspection Report (2018) Good' for the Trust<br>• HFEA Inspections<br>• H&S Executive Inspections<br>• Fire Service Inspections<br>• Safeguarding Regulatory Inspections | **Outcomes**<br>• Collaborative meetings with CCG<br>• CQC assessment form 2018 visit as 'Good' for the Trust<br>• CQPG bi monthly meeting between LWH and LCCG<br>• NHSE/I reviews with LWH<br>• External Auditors | | |



| Inherent risk level | | | Current risk level | | | Target risk position by 31.3.20 | | |
|---|---|---|---|---|---|---|---|---|
| Likelihood | Impact | Score | Likelihood | Impact | Score | Likelihood | Impact | Score |
| 5 | 4 | **20** | 3 | 4 | **12** | 2 | 4 | **8** |

**Strategic Objective:** To deliver **safe** services

**Risk Appetite:** Low

**Objective:** Long-term clinical sustainability (Electronic Patient Record)

**CQC Domain:** Safe

**Enabling Strategy:** Risk Management Strategy / IM&T Strategy

**Executive Lead:** Andrew Loughney

**Operational Lead:** David Walliker

**Assurance Committee:** Quality Committee (QC)

| Risks to objective | Controls | Gaps in controls | Sources of assurance | Assurance outcomes / gaps | Action plan | Timescales |
|---|---|---|---|---|---|---|
| **Principal Risks – 2184**<br><br>**Condition:**<br>Failure to deliver an integrated EPR against agreed Board plan (Dec 2016)<br>Failure to Deliver at proposed schedule May 2020.<br>Implementation of a system that is not fit for purpose<br><br>**Cause:** Poor program management and product design<br><br>**Consequence:**<br>Impact on Patient Safety Quality and Experience<br>Impact on patient and clinical services, such as e-prescribing, staff documentation and consent.<br>Unable to meet contractual reporting arrangements linked to performance and finance<br>Financial impact on delivery of control total leading to inability to deliver annual plan. | • EPR programme board chaired by AUHT CEO and attended by executive directors, CIO and CCIO<br>• Governance structure for project in place with independent reviews<br>• LWH Digital Hospital sub-committee review of project in place with DoF chairing<br>• Oversight of programme by FPBD (inc NEDs).<br>• Monthly IM&T mangers operational meetings in place<br>• PID in Place<br>• Testing programme for system in place prior to implementation<br>• Communication plan in place<br>• Benefit Strategy<br>• Clinical leadership identified<br>• Training and engagement plan in place | • Concern as to supplier management and product functionality UK Market<br>• Programme board ineffectiveness<br>• Lack of confidence in plan<br>• Test cycle may be ineffective and if not signed off will impact on programme<br>• Unable to train staff until system has been signed off which may lead to a delay<br>• Key partner awaiting NHSI approval and has not agreed contract with supplier | **Management assurance**<br>• Executive Sign off initial programme plan<br>• Clinical (operational) sign off<br>• Exec Team Briefings from CIO<br>• Oversight from Digital Hospital Sub-group<br>• Regular reporting to FPBD<br>• MIAA gateway reviews<br>• Clinician engagement undertaken<br>• Report from NHS Digital (expected March 19)<br>• Independent review to Director of Finance<br><br>**Metrics**<br>• Monthly reports to show progress against plan<br>• Highlight report presented against milestones<br>• Monthly review at FPBD<br><br>**Independent / semi-independent**<br>• MIAA Report (limited assurance) 2017<br>• Gateway process in place with external verification<br>• NHS Digital review (due March 19)<br>• Independent review to Director of Finance (April 19) | **Gaps**<br>• Ability to influence supplier<br>• Functionality of modules for Maternity, Theatres and e-prescribing<br>• Appetite of other Trusts to prioritise the program<br>• Effectiveness of Program Board in delivering the solution.<br>• Effectiveness of supplier and product as evidenced by Digital and Independent reports<br><br>**Outcomes**<br>• No impact on the delivery of control total<br>• Supports the delivery of CIP<br>• Delivery of safe EPR against revised plan. Plan due July 2019 | • Test System built and tested against clinically approved script with additional scrutiny and assurances around areas highlighted as a concern.<br><br>• Recommendations undertaken of audit and repeat audit by MIAA<br><br>• Recommendation to Trust Boards from EPRL Programme Board following review of Digital report and actions to continue or not.<br><br>• Delivery of live system against design and configuration set-out through the programme and clinically signed off.<br><br>• Completion of the business intelligence strategy to enable the successful delivery of statuary and operational reporting post deployment | • TBC 2020<br><br>• July 2019<br><br>• July 2019<br><br>• As part of above<br><br>• May 2020 |
| **Risks from Risk Register**<br>• 2024 – IM&T service risk | | | | | | |



| Inherent risk level | | | Current risk level | | | Target risk position by 31.3.20 | | |
|---|---|---|---|---|---|---|---|---|
| Likelihood | Impact | Score | Likelihood | Impact | Score | Likelihood | Impact | Score |
| 5 | 5 | **25** | 5 | 5 | **25** | 5 | 5 | **25** |