Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

Board of Directors Meeting

HELD IN PUBLIC

7 November 2019

Meeting of the Board of Directors
HELD IN PUBLIC
Thursday 7 November 2019 at 0930hrs
Liverpool Women's Hospital
Board Room

Item no. 2019/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
	Thank you	To provide personal and Team thank you – above and beyond			0930 (10mins)
159	Apologies for absence Declarations of interest	Receive apologies	Verbal	Chair	
160	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written	Chair	
161	Patient Story	To receive a patient's story	Presentation	Gynaecology	0940 (20mins)
162	Minutes of the previous meeting held on 5 September 2019	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1000 (5mins)
163	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
164	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1005 (10mins)
165	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1015 (10mins)
BOARD COMMITTEE ASSURANCE					
166	Chair's Report from Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1025 (20mins)
167	Chair's Report from Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
168	Chair's Report from Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
169	Chair's Report from Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
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					
170	Clinical Summit – Summary of Outcomes	For assurance	Written	Medical Director	1045 (10mins)
171	Learning from Incidents Report	For assurance	Written	Director of Nursing and Midwifery	1055 (10mins)

Item no. 2019/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
172	Freedom to Speak Up - Self Review Tool and Strategy	For assurance	Written	Director of Workforce and Marketing	1105 (10mins)
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES					
173	Safer Nurse/Midwife Staffing Monthly Report period M6 2019/20	For assurance and to note any escalated risks	Written	Director of Nursing and Midwifery	1115 (5mins)
174	Operational Performance Report period M6, 2019/20	For assurance –To note the latest performance measures	Written	Director of Operations	1120 (10mins)
175	Finance Report period M6, 2019/20	For assurance - To note the current status of the Trusts financial position	Written	Director of Finance	1130 (10mins)
TRUST STRATEGY					
176	Nursing & Midwifery Strategy	For approval	Written	Director of Nursing and Midwifery	1140 (5mins)
BOARD GOVERNANCE					
177	Board Assurance Framework 2019/20	For assurance and approval	Written	Trust Secretary/ Executive Lead	1145 (10mins)
178	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	(5mins)
HOUSEKEEPING					
179	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1200 Meeting ends

Date of next meeting

Board in Public: 5 December 2019

Meeting to end at 1200

1200-1215	***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

Liverpool Women's

Meeting attendees' guidance, April 2019

Under the direction and guidance of the Chair, all members are responsible for ensuring that the meeting achieves its duties and runs effectively and smoothly. At all times the members should be cognisant of the meetings Terms of Reference.

Before the meeting

- Prepare for the meeting in good time by reviewing all reports
- Submit any reports scheduled for consideration at least 8 days before the meeting to the meeting administrator for issue 7 days before the meeting (see bullet 2 below under Standards and Obligations)
- Ensure your apologies are sent if you are unable to attend and *arrange for a suitable deputy to attend in your absence
- Notify the Chair in advance of the meeting if you wish to raise a matter of any other business

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

At the meeting

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

Attendance

- Members are expected to attend at least 75% of all meetings held each year. Please check Terms of Reference of the Committee on each committees requirement.

After the meeting

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

Standards & Obligations

1. All documentation will be prepared using the standard Trust templates. A named person will oversee the administrative arrangements for each meeting

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

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

Liverpool Women's NHS Foundation Trust

Board Agenda item 2019/162

Board of Directors

Minutes of the meeting of the Board of Directors
held in public on 5 September 2019
at Liverpool Women's NHS Foundation Trust, Crown Street Liverpool.

PRESENT

Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Mrs Michelle Turner	Director of Workforce & Marketing & Deputy Chief Executive
Mrs Jenny Hannon	Director of Finance
Dr Devender Roberts	Acting Medical Director
Mr Phil Huggon	Non-Executive Director
Mr Tony Okotie	Non-Executive Director/SID
Prof Louise Kenny	Non-Executive Director
Mrs Tracy Ellery	Non-Executive Director
Mr Ian Knight	Non-Executive Director
Dr Susan Milner	Non-Executive Director
Ms Jo Moore	Non-Executive Director & Vice Chair
Mrs Caron Lappin	Director of Nursing and Midwifery
Mr Gary Price	Director of Operations

IN ATTENDANCE

Mr Colin Reid	Trust Secretary

APOLOGIES:

2019	**Thank You** **Mother and Child Sculpture** – The Chief Executive introduced Terry McDonald to the Board explaining that Terry was not aware of the invitation and that he had been invited through his wife, to receive the special thank you. The Chief Executive advised that Terry was the creator of the 'Mother and Child' statue outside of the Trust and that this year marked the 20th anniversary of its inauguration. The Chief Executive added that the Statue had been such a feature of the Hospital for so long and was recognised by patients and visitors as a place where women and babies could receive the highest quality of care. She advised that it was a common occurrence that mums and babies have their photographs taken in front of the Statue as they leave the Trust. The Chief Executive presented Terry with a framed photograph of the 'Mother and Child' with the inscription: "The Statue 'Mother & Child' by sculptor Terry McDonald was unveiled in April 1999 and during this time 160,000 babies have been born at the Liverpool Women's. With grateful thanks from the Liverpool Women's NHS Foundation Trust, 5 September 2019.". Terry thanked the Chief Executive for her kind words and gifted to the Trust his set of early photographs and drawings arising from the creation of the Statue.

	David Walliker – The Director of Finance provided the thank you on behalf of the Board to David Walliker, the outgoing Chief Information Officer. She advised the Board that David was leaving his role and that of CIO at the Royal to take up a new role as Chief Digital and Partnership Officer at Oxford University Hospitals NHS Foundation Trust. The Director of Finance advised on the amazing things that the Trust had been involved in and achieved over the last six years, referring to the Trust's status as a Global Digital Exemplar, achieving Hymex level 5 and the incredible work in developing the Trust's cyber essentials infrastructure. Ending the thank you the Director of Finance also commented on David as a great colleague who would be missed.
128	**Apologies** – as above. **Declaration of Interests** – None **Welcome:** The Chair opened the meeting and welcomed everyone present, in particular he welcomed Gary Price to his first Board meeting as Director of Operations.
129	**Meeting guidance notes** The Board received the meeting attendees' guidance notes. The Chair advised that due to the availability of the patient story he had brought forward the Safeguarding presentation.
130	**Safeguarding Annual Report presentation – specific to Board responsibility** The Board was joined by Mandy McDonough, Associate Director of Nursing and Midwifery for Safeguarding; Matt O'Neill, Safeguarding Governance and Assurance Lead; and Carl Griffiths, Named Nurse, Safeguarding Adults who provided a presentation setting out the role and scope of practice of the safeguarding team, the Trust's statutory Partners, Regulation and Board responsibilities. The Presentation included details of the 'things' that the Trust was proud of in the provision of the safeguarding services and the significant assurances the Trust had received from the internal audit of the services by MIAA. The Chief Executive referred to a recent meeting with a District Judge regarding two concerns raised: the first related to new born babies and Interim Care Orders (ICOs) and the second related to processes in relation to court orders and requests from the Courts to Liverpool Women's Hospital. Amanda McDonough reported that the meeting had highlighted a level of concern surrounding communication and delays in obtaining ICOs arising within the Local Authority. She explained that the District Judge was clear in saying that if an ICO was required then the Courts should be flexible to arrange an emergency hearing if needed and the District Judge did not understand why this had not been communicated to the Trust; the District Judge had also commented that the Legal Teams should contact the Trust's Safeguarding Team directly to discuss what was needed from clinical staff and should not contact the wards directly. Referring to the Court Requests, Amanda McDonough advised that she had raised concerns that the requests were becoming unmanageable as they required both medical records and separated clinical reports. Amanda McDonough advised that the District Judge had ruled that only medical records were required for judges to make decisions. The Chief Executive thanked the Safeguarding team for their presentation and asked whether the issues with the Local Authorities and the Courts had been concluded. Amanda McDonough reported that there had not been any requests for separate clinical reports since the meeting went on to report that in respect of the delays for ICO's the Safeguarding Team had been led to believe by the Local Authority that it was the court delaying processes; however, since the meeting there had been no delays.

	In response to a question from Phil Huggon regarding any concerns that affected the Service, Amanda McDonough reported that the delays in the delivery of a shared EPR was a cause for concern. She explained that there were different referral processes adopted at each trust and therefore could potentially affect the quality of outcomes for patients/service users should the services be merged. Amanda McDonough advised that the Trust had in place a robust referral process in place that referred directly to the Safeguarding team by staff. Aintree and the Royal however did not have such a system in place relying on clinician referrals who did not have the same skill set as a Safeguarding Practitioner. Amanda McDonough and Carl Griffiths highlighted several issues externally with regards to partner agencies and the lack of appropriate process within those organisations; explaining that austerity measure had led to losing posts in Safeguarding. This had resulted in continual challenge with partners sometimes on a daily basis to ensure the correct safeguarding processes were followed; this continual challenge was extremely time consuming for the Team. Amanda McDonough advised that the matter would be raised with Liverpool CCG's Safeguarding colleagues at a Site Visit on Tuesday 10th September. The Chief Executive recognising the pressures on the team asked whether there was enough resource to do the work, Amanda McDonough reported that although referrals had almost doubled in some areas, the team was currently managing; however, she was monitoring the position and would discuss with the Director of Nursing and Midwifery should it became an issue. The Chair on behalf of the Board thanked the Safeguarding team for their presentation
131	**Minutes of previous meeting** The minutes of the board meeting held on 4 July 2019 were approved.
132	**Matters arising and action log.** University of Liverpool: Referring to the action outstanding on the action plan, the Acting Medical Director reported on the ongoing discussions she was having with the University of Liverpool regarding the University's appetite to support academic posts for the hard to recruit specialities at the Trust. This action would remain on the action plan for future reporting following the ongoing discussions.
133	**Chair's Announcements** The Chair reported on the following matters: **Trust Apprentice Scheme with Southport College:** The Chair reported on the second passing out ceremony for apprentices at the Trust in collaboration with Southport College. He advised that there were some very heart-warming stories from students who had undertaken the scheme. The Director of Workforce and Marketing advised that the Scheme would continue and that she and her team were looking at extending it to include individuals with autism. **Liverpool University Hospitals NHS Foundation Trust:** The Chair reported on the current status of the merger between Aintree University Hospital NHS Foundation Trust and Royal Liverpool and Broadgreen University Hospitals NHS Trust to create Liverpool University Hospitals NHS Foundation Trust. He advised that the Chair of the merged entity, Susan Musson had been appointed and the together with the appointment of the Chief Executive, Steve Warburton; the process of appointing the Executive Directors was ongoing and would be concluded in time for the merger on 1 October 2019.

	The Chair advised that arrangements were being made for him and the Chief Executive to meet with Susan Musson and Steve Warburton as soon as possible after the merger to continue the close relationships that currently exist between the trusts. The Board noted the Chair's verbal update.
134	**Chief Executive's report** The Chief Executive reported on a number of items from her report, in particular referring to the Annual Remembrance Service that was due to take place on 14 October 2019. The Chief Executive advised that this year the Trust was holding 2 services on the same day following feedback gained from families who attend; an earlier service for adults and children would be held from 4pm followed by a later service just for adults at 7:15pm. The Chief Executive advised that the services coincided with national baby loss week. Referring to the Division of Family Health the Chief Executive reported that the Trust was in full compliance with all 10 safety steps within the CNST Maternity incentive scheme; this was achieved following the successful completion of MPET training. The Chief Executive reminded the Board that it had approved the Trust submission on 8th August in time for submission on 12 August 2019. The Chief Executive also referred to the funding secured in Maternity for a National Advanced Maternity Practitioner programme; the Trust would be the first Trust in the country to train ACP midwives with six midwives commencing the course in September 2019. Referring to the Single Oversight Framework reported in her Report, the Chief Executive advised that further reporting of the requirements would be taken through the Finance Performance and Business Development Committee in due course. The Chief Executive asked the Trust Secretary to distribute the briefings received from NHS Providers and NHS Confederation. The Chief Executive reported on the recent capital investment made by the department of Health and Social Care and advised that the amount of money invested, £1.8b was in fact already held within the organisations who received the "funding" and was not new money. She explained that this money pushed against the CDEL ceiling. The Chair thanked the Chief Executive for presenting her Report, which was noted.
135	**Chair's Report from Quality Committee (QC)** Phil Huggon presented the Chair Report from the Quality Committee meeting held on 22 July 2019 and advised that the Committee continued to receive assurance from each of its sub-committees/senates on the work they had been carrying out. Referring to the BAF, Phil Huggon advised that the Committee had reviewed the quality related risks and received assurance that the risks attributed to the Committee were being managed appropriately. He reported that consideration was being given by the Acting Medical Director to the inclusion of Maternal Medicine on the BAF and any proposal would be presented to the Committee before coming to the Board for approval. The Acting Medical Director provided a short explanation of the reasons behind the addition of the risk which related to the clinical sustainability of remaining on an isolated site, and that a more in-depth explanation would be provided to the Quality Committee for its consideration. The Acting Medical Director was not certain at this time whether it would be a new BAF risk or whether it was a subsidiary risk to the BAF risk relating to long term clinical sustainability. The Chair asked that the risk was considered in full to include, the number of women this impacted on, what mitigations could be put in place and what the implications were for the women of Liverpool.

	The Chief Executive advised that the concerns being raised now relate to those that first moved the Trust to develop the Future Generations Strategy; advising that these risks were now beginning to be realised. She advised that the Future Generation Strategy sought to mitigate the risks of remaining on an isolated site and felt that the delays in finding the capital to move the Trust continued to have a negative impact on the women of Liverpool in the provision of services. The Chief Executive recognised that the impact would also be felt through the difficulties in retaining and recruiting consultants as they would not want to work in a system that did not allow for the best possible outcomes for their patients. Referring to the Serious Incident Reporting the Chair requested that future reports into the Board should include what learning the Trust had garnered from the incidents, how the Trust had learnt from the incidents and how the learning was disseminated across the Trust. He asked that this should be provided at the 7 November Board meeting. *Action2019/135: The Director of Nursing and Midwifery to provide to the meeting on 7 November 2019 a Serious Incident Report that included what learning the Trust had garnered from the incidents, how the Trust had learnt from the incidents and how the learning was disseminated across the Trust.* The Chair thanked Phil Huggon for his report which was noted.
136	**Patient Story Presentation** **Fertility - Supporting patients once they reach the end of their fertility journey** Rachel Gregoire, joined the meeting to present a patient story that provided the Board with an understanding of the needs of patients using the fertility services and the emotional impact that decision making had on the patients. Rachel Gregoire advised that a couple had received notification from the Trust that their embryos were due to be removed from storage to perish due to the current time requirements for storing embryos. She advised that contact with the patients had been made through an impersonal letter sent out by the administration team in accordance with the Trust's processes. On receipt of the letter the patients were extremely upset and due to their own emotional state in being unable to cope with their own infertility and were unable to let the embryos perish. Rachel Gregoire advised that with support and counselling from the Trust they finally accepted closure and allowed the embryos to perish with a private burial. Rachel Gregoire advised that lessons had been learnt from the patient story which included: multidisciplinary teams (administrative, counselling and scientific) working in partnership that helped the couple reach closure; and careful planning allowed the couple to be supported when making their final decision on the fate if their embryos and ensured the couple felt empowered and respected in their decision to perform a private ceremony and burial for their embryos. Rachel Gregoire advised that changes were being considered that includes: the administration team to ask PR for advice/support with all patients requesting extended embryo storage; encouragement of all fertility staff to continue to follow up on patients who need additional support; and the formulation of an Emotional Support Policy to support patients before and after fertility their treatment. The Chief Executive thanked Rachel Gregoire for her presentation commenting on the very human side of supporting patients that the Trust had to deal with day to day, with staff going that extra mile. The Director of Workforce and Marketing commented that sometimes the Trust gets it wrong and desensitise and act in an impersonal manner in the way it communicates with patients; in this instance the Trust did get it wrong at first and the Trust needed to learn from this.

	The Chief Executive commented that the Director of Nursing and Midwifery and Acting Medical Director were currently reviewing letters and communications to patient to address the need for them to be more sensitive to the emotion of the situation. The Board noted the patient story, the lessons learned, and actions being taken to improve the Trust's communications with patients.
137	**Chair's Report from Finance, Performance and Business Development Committee (FPBD)** Phil Huggon presented the Chairs Report from the meeting held on 22 July 2019. Referring to operational performance for RTT and Cancer, Phil Huggon advised that the Committee had received further updates on the Trust's performance and recognised that challenges continued in achieving cancer and RTT targets. He noted that this would be discussed later in the meeting within the Operational Performance Report. Phil Huggon advised that the remainder of the Report should be taken as read noting that further discussions would take place on the Single Neonatal Service and EPR in a separate forum. The Chair thanked Phil Huggon for his report with was noted.
138	**Chair's Report from Audit Committee** Ian Knight Chair of the Audit Committee presented his Chairs report from the meeting held on 22 July 2019 and ran through the assurances the Committee had received from the meeting. Ian Knight referred to the paper the Committee received setting out proposals for the repayment of revenue loans with the Department of Health and Social Care; the Committee noted that the Trust was in a strong cash position and supported the proposal to repay all its remaining revenue loans of £6.3m. The Director of Finance advised that the repayment of the loans had been completed and this was reported in the Finance Report to be taken later in the meeting. Referring to the action required by the Board, Ian Knight advised that the Committee had considered amendments to the standardised terms of reference relating to individuals external to the Trust invited to attend meetings of the Board committees. The Board reviewed and approved the proposed amendment to the standardised terms of reference, noting that the amendment would be with immediate effective and that each of the Board Committee Terms of Reference would be amended accordingly. The Chair thanked Ian Knight for his report which was noted.
139	**One to One (North West) Limited update report** The Director of Nursing and Midwifery presented the One to One (North West) Limited update paper and explained the consequential actions taken by the Trust to support women who had been receiving their maternity care from One to One at the time the company went into administration. The Director of Nursing and Midwifery advised that the main driver for the Trust and staff was to keep those women safe during the period of uncertainty. The Director of Nursing and Midwifery ran through the immediate actions taken by the Trust to support the system and highlighted the issues and concerns the Trust had top address to support those women presenting to the Trust. The Director of Nursing and Midwifery summarising her report advised that the initial requirements to contact women and provide appropriate and safe care had been undertaken by the Trust and a named midwife identified with appropriate plans of care put in place for the women, for the

	continuation of their pregnancy. Referring to postnatal women and babies, these continued to receive care by the community midwifery service. The Director of Nursing and Midwifery advised that NHS Wirral would be undertaking a post incident review with the support from NHS England/Improvement; there was also an intention to commission an independent clinical and contracting review of One to One (North West) Ltd covering the seven years of their operation in Cheshire and Merseyside to identify lessons learnt. The Chair asked whether the Director of Nursing and Midwifery was assured that no patients came to any harm because of the collapse of One to One. In response the Director of Nursing and Midwifery advised that there were some safeguarding issues that needed to be addressed and this was undertaken by the safeguarding team. She went on to advise that given the actions taken by the Trust and other providers she was assured that patients presenting at the Trust came to no harm because of the collapse of One to One. Tony Okotie commented on the comprehensive actions taken by the Trust and congratulated the teams involved; he felt that the Board should receive the outcome of any independent review of One to One. The Chief Executive advised that One to One had circa 1800-2000 patient on its books, who within a matter of 48 hours' notice had no provision od care and was pleased that the Trust was able mobilise itself to support those patients wanting to be booked in at the Trust within a very short timeframe. She felt that anything other than an independent inquiry was not good enough and felt that the Board should make this clear should any review fall short of this. Phil Huggon questioned how the mobilisation of the Trust would be funded in light of the number of staff required to support the patients. The Director of Finance advised that the Trust had made representations with Wirral CCG not only in terms of the funding following the collapse of One to One but also regarding the debt that was outstanding. Susan Milner referring to the comment in the paper, that some patients did not realise the Trust provided community midwifery, asked whether the Trust was considering promoting this service in the near future. The Director of Nursing and Midwifery advised that some of those not aware of the service were not within the Trust's catchment area for community midwifery. She was however looking into what could be done. The Chair thanked the Director of Nursing and Midwifery for her report and was pleased that the Trust was able to mobilise its NHS resource in support of the care of patients and thanked the staff. The Board noted the actions taken by the Trust and received assurance that the actions taken provided safe services to women presenting to the Trust who had previously been registered with One to One.
140	**Single Neonatal Service Update** The Director of Operations present the paper updating the Board on the status of the Single Neonatal Partnership. The Director of Operation reported on the key highlights explaining that the leadership team had now been appointed which included Dr Chris Dewhurst, as Director of Neonatal Services and Jennifer Deeney, Head of Nursing. The Director of Operations referred to the current discussions with NHSE Specialist Commissioners with regards to long term funding of the programme which was work in progress. In response to a question on capital funding for a Neonatal Unit at Alder Hey, the Director of Operations reported that Alder Hey had reported that they had the available capital. The Chair thanked the Director of Operations for his report which was noted and agreed that the Board would receive a Single Neonatal Service Update at future Board meetings.

141	**Safer Nurse/Midwife Staffing Monthly Report period M4 2019/20** The Director of Nursing and Midwifery asked that the paper be taken as read and discussed. The Board received the report, noted the contents and was assured that appropriate information was being provided to meet the national and local requirements. The Board was further assured that the Trust had the appropriate number of nursing and midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Director of Nursing & Midwifery.
142	**Operational Performance Report Month 4, 2019/20** The Director of Operations presented the Operational Performance Report for month 4 2019/20. He reported that challenges continue in achieving RTT 18 Week referral to treatment, with focus on the clinical priority of long waiting patients. He advised that this was evidenced by a sustained 52-week position and significant reduction in overdue follow-ups across the specialities. Referring to Cancer, the Director of Operation's reported that the Trust continued to achieve the 2-week target, however colposcopy referrals continued to see an increase in month in response to the national campaign. Meeting the 62-day target continued to be challenging in June, with performance decreasing to 22%; however, the quarterly position remained higher than the corresponding 18/19 quarterly performance, carrying on the general improvement from Q4 2018/19. The Director of operations reported that ten patients had not treated within the 62-day target; there were 3 main reasons, either medical issues in terms of not being fit for surgery, late referrals from other trusts or issues with clinical capacity. The Director of Operations drew the Board attention to the work of the Cheshire and Mersey Cancer Alliance which would be held to account for improving cancer performance with a view to addressing the regional failure to achieve the 62-day target. He reported that the Trust was fully engaged in this work which was due to commence in September 2019 and ongoing updates on the work of the Cheshire and Mersey Cancer Alliance would be provided to the Board committees. The Chief Executive advised on the current availability of Gynaecology oncologists within the Trust and reported that one consultant had recently resigned from his post leaving three consultants in post. She explained that one of the three was on long term sick leave and therefore there was considerable pressure on the remaining two consultants. The Chief Executive raised concern on the continued sustainability in undertaking complex work on the isolated site. Referring to the difficulties in recruiting Gynaecology Oncologist and Endometriosis consultants. She advised that continuing to provide services whilst on an isolated site was going to become unviable and unsustainable with the possibility of patient having to be treated in Manchester. The Chair asked that future reports include the trajectory for RTT and cancer and that it highlighted key points that could impact on delivery. The Chair thanked the Director of Operations for his report, the content of which was noted.
143	**Financial Report & Dashboard Month 4, 2019/20** The Director of Finance presented the Finance Report and financial dashboard for month 4, 2019/20 and reported that at month 4 the Trust was reporting a deficit of £0.4m against a deficit budget of £0.6m, giving a year to date favourable variance of £0.2m. She advised that the forecast had been maintained at the breakeven plan at this early stage in the year. Referring to the divisional performance, the Director of Finance advised that other than Gynaecology, all areas were close to plan and forecasting delivery of their yearend financial targets. She reported that Gynaecology Division's forecast had deteriorated at Month 4; the year to date adverse variance

	was £1.1m which had deteriorated from £0.7m at Month 3 with the division forecasting an overspend of circa £2m for the full financial year. The Director of Finance reported that Agency costs were significantly above budget and advised that the Trust could not continue to sustain this level of expenditure as the cap, set by NHS Improvement, would be breached. The Director of Finance advised that the increased agency spends were attributable to Gynaecology and Finance. She advised that plans were underway to reduce agency spends in both areas. Referring to the earlier discussion regarding One to One, the Director of Finance advised that the Trust was in communication with the administrators of One to One regarding the current debt of £0.5m. She explained that, given the financial status of One to One when it went into administration, it is unlikely that there would be sufficient assets remaining to pay unsecured creditors and as explained earlier the Trust had raised this with commissioner of services. The Chair referred to the Cost Improvement Programme and that a considerable amount of CIP was being programmed to be delivered towards the end of the Financial year. He asked that the Finance, Performance and Business Development Committee continue to keep CIP in its line of sight. The Chair thanked the Director of Finance for presenting the Financial Report & Dashboard month 4, 2019/20 which was received.
144	Future Generations – Clinical Sustainability of Services The Chief Executive updated the Board on the work being undertaken to address the options open to the Trust on the availability of capital and ensuring that as a local system the Trust remained the number one priority. She advised that there had been a number of changes regarding system leadership with the appointment of Ann Marr as the new Chief Executive of the Acute Sustainability Board. The Chief Executive advised that Ann Marr fully understood the clinical issues faced by the Trust and was fully supportive of the need to move off the isolated site. Referring to the clinical summit held in June, the Chief Executive advised that plans were being developed to address the significant clinical issues raised during the day. She explained that there was a need to set out clearly the timescales by which some of the more complex work undertaken by the Trust would need to stop and transfer to those providers able to undertake the work within the North West. The Chief Executive advised that the One Liverpool Strategy was currently being developed with the final draft being discussed in October. She understood that the Board would receive a presentation of the final Strategy at its meeting on 7 November 2019.
145	Board Assurance Framework The Trust Secretary presented the Board Assurance Framework 2019/20. He advised that this was the first report to the Board that had been produced from Ulysses, the risk software package. The Board noted that there had been no change to the BAF since the last report following review by the Executive and Board Committees. The Board received the Board Assurance Framework and confirmed that the Board Assurance Framework adequately identified the principal risks to achieving the Trust's strategic objectives. Tony Okotie commented on the report and asked that consideration to summarising the new document so that it made for easier reading. The Trust Secretary agreed to take this up with the Head of Governance and Quality.

146	**Review of risk impacts of items discussed**
	The Board noted the following additional risks identified during the meeting:
	• Safeguarding risks regarding merger
	• Single Oversight Framework and the implications on the Trust
	• Impact on Services
	  • risks attributable to Maternal Management
	  • Communications to Patients being sensitive to the emotion of the situation.
	  • Risks attributable to the demise of One 2 One
	  • Financial pressure and risk to delivery of CIP

147	**Any other business & Review of meeting** There was no other business. The Chair thanked all the various guests for their attendance. The Board felt that the meeting met the objectives of the agenda items and assurance on the activities of the Trust. The Board agreed that there was honest, transparent, frank and challenging discussion on items presented. The Chair reported that this would be the last formal Board meeting in public that the Trust Secretary would be attending having taken up a new role outside of the NHS. The Chair on behalf of the Board and him personally thanked the Trust Secretary for his diligence and hard work.
	Date of next meeting The Chair reported that the next meeting of the Board in public would be 7 November 2019.

TRUST BOARD
7 November 2019
Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
4 Jul 2019	2019/105	The Acting Medical Director to progress formalising of a Trust Research Committee.	Acting Medical Director	In progress	Arrangements are currently being put in place with the Director of Research and Development. An update on progress will be made at the Quality Committee on 23 September 2019.
4 Jul 2019	2019/108	The Acting Medical Director to take forward with the University of Liverpool the possibility of supporting academic posts in hard to recruit to specialties.	Acting Medical Director	In progress	Initial discussions have progressed with University of Liverpool. Further report will be provided at the Board meeting on 5 September 2019. 5 September 2019 – The Acting Medical Director briefed the Board on current progress. It was agreed that the matter should remain on the Action Plan as an open action.
5 Sep 2019	2019/135	The Director of Nursing and Midwifery to provide to the meeting on 7 November 2019 a Serious Incident Report that included what learning the Trust had garnered from the incidents, how the Trust had learnt from the incidents and how the learning was disseminated across the Trust.	Director of Nursing & Midwifery	Completed	Report included on the agenda for the Board of Directors meeting on 7 November 2019.

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

Liverpool Women's NHS Foundation Trust

Agenda Item	2019/165

MEETING	Board of Directors
PAPER/REPORT TITLE:	Chief Executive Report
DATE OF MEETING:	Thursday, 07 November 2019
ACTION REQUIRED	Information
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	Paul Buckingham, Interim Trust Secretary
STRATEGIC OBJECTIVES:	*Which Objective(s)?* 1. To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☒ 2. To be ambitious and ***efficient*** and make the best use of available resource ☒ 3. To deliver ***safe*** services ☒ 4. To participate in high quality research and to deliver the most ***effective*** Outcomes ☒ 5. To deliver the best possible ***experience*** for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	*Which condition(s)?* *1. Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ *2. Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒ *3. The Trust is not financially sustainable beyond the current financial year……* ☒ *4. Failure to deliver the annual financial plan ……* ☒ *5. Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ *6. Ineffective understanding and learning following significant events……* ☒ *7. Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ *8. Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒
CQC DOMAIN	*Which Domain?* ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐

	ALL DOMAINS ☒			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	1. Trust Constitution ☒ 2. Operational Plan ☒ 3. NHS Compliance ☒		4. NHS Constitution ☒ 5. Equality and Diversity ☒ *6.* Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: *(eg: The Board/Committee is asked to:-….)*	*Board is asked to 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

Meeting with North West Region Medical Director: The Medical Director and Director of Nursing & Midwifery met with Dr D Levy, North West Region Medical Director, on 17 October 2019 to discuss matters relating to the sustainability of services on the Crown Street site. Areas of particular focus during the meeting included; gynaecological oncology, complex benign gynaecology, high dependency unit provision, maternal medicine services and the associated challenges of the recruitment and retention of senior medical staff. While Trust representatives emphasised that a truly sustainable solution necessitate relocation of the hospital, details of mitigating actions taken to date were shared with Dr Levy together with an outline of plans for further mitigation through enhancements to services on the Crown Street site. We were pleased that Dr Levy encouraged the need for a system-wide response to support the Trust which could include the establishment of a Single-Issue Quality Surveillance Group with representation from across Cheshire & Merseyside. The Medical Director took the opportunity to describe parallel plans for the establishment of a Partnership Board with Liverpool University Hospitals NHS Foundation Trust to further develop the 'virtual bridge' between the two organisations with respect to the provision of clinical care.

Flu Vaccinations 2019/20: The flu season is now upon us and, as a Trust, we will try to take every precaution to keep our patients and our staff safe. The flu vaccination is available to every member of staff to protect them from the risk of flu and its complications. A comprehensive vaccination programme commenced on 7 October 2019 and will continue throughout the winter period. I strongly encourage all staff to have the vaccination at the earliest opportunity in order to protect themselves and their patients.

This year's CQUIN target for vaccinations has increased to 80% of frontline clinical staff, although we will aspire to vaccinate all frontline clinical staff. 34.2% of frontline clinical staff had been vaccinated as of 30 October 2019. The Trust has also completed a flu vaccination checklist provided by NHS England to enable the Board to provide public assurance on its arrangements by December 2019. The completed checklist is attached as a separate paper to this report.

NHS Staff Survey 2019: Survey forms, some paper copy, some electronic copy, have been distributed to staff across the Trust, giving plenty of opportunity to complete the survey before the closing date of 29 November 2019. Email survey reminders and reminder letters for individuals who received paper surveys have also been distributed to those who have yet to complete the survey. The reminders are issued by the external company coordinating the survey so, whilst receipt of a reminder highlights those who have yet to return their survey, staff can be assured that the Trust does not have access to individual survey responses. The outputs from the Staff Survey are really important in reflecting the views of staff in future planning and I would strongly encourage completion of the survey.

'Hospital' Documentary Series: Label 1 Television and the BBC will be returning to Merseyside for Series 5 of the award-winning documentary series 'Hospital'. Filming will take place at several trusts in Liverpool, including Liverpool Women's Hospital, and the programme will be screened on BBC Two in 2020. Filming was due to commence on 28 October 2019 and the Label 1 team held a series of drop-in sessions at the Trust to brief interested staff on the approach to filming and address any concerns and/ or questions.

Council of Governors' Elections 2019: I am delighted to announce that the following candidates were elected to the Council of Governors in the 2019 elections:

Staff

- Pauline Kennedy – Scientists, Technicians and Allied Health Professionals constituency
- Nigel Parsons – Scientists, Technicians and Allied Health Professionals constituency

Public

- Sara Miceli-Fagrell – South Liverpool Public constituency
- Jackie Sudworth – Knowsley Public constituency
- Evie Jefferies – Rest of England and Wales Public constituency.

Each of the above were elected for three-year terms commencing on 3 October 2019 and I look forward to meeting the new Governors at the next Council of Governors meeting on 6 November 2019.

Division of Family Health:

a) **'Going Home' Checklist:** This has now been implemented as day to day practice across the Maternity service following a successful pilot phase. The practice involves 'taking a moment to think about today' and to consider

three things that went well and three things that did not go well and to check on colleagues wellbeing before they leave at the end of shift. The Professional Midwifery Advocate (PMA) is available to offer support and any matters that require escalation can be referred to the Senior Team for a 24/7 response.

b) **Maternity Commendation:** The service has been highly commended by the Royal College of Midwives for its 'Newly Qualified Package' and 'Excellent Preceptorship Programme'. Newly qualified staff are issued with a NQ badge which identified newly qualified midwives so that other staff can provide support if required.

c) **Neonatal Re-Development:** The new-build project continues to progress well with the overall programme subject to just a 2-3 week slippage, with the potential that this could be recovered over the remainder of the build programme. An artist has been commissioned to work with the Trust on the art design of the Unit and work has been undertaken with Communications Team colleagues to commence planning for the official opening of the unit in 2020.

Clinical Support Services Division:

a) **Referral to Treatment Training:** Referral to Treatment (RTT) training has been rolled out across the Trust for all staff who 'touch' a patient pathway. Staff are required to complete a short online test with classroom-based training available should further support be required.

b) **Reducing Sample Errors:** Work is continuing with each Division to reduce the level of sample taking errors and further work is planned to close the loop on learning from such incidents. This will include supporting staff to ensure compliance with laboratory acceptance criteria and a mechanism for staff to feedback to laboratories should any issues with consumables be experienced.

c) **Staff Governor:** Nigel Parsons, Divisional Matron, was successfully elected to represent the Scientists, Allied Health Professionals & Technicians staff constituency on the Council of Governors.

Gynaecology:

a) **Accreditation:** The Hewitt Andrology Laboratory has successfully achieved the UKAS accreditation.

b) **Staffing:** A Band 6 Colposcopy nurse has been appointed as part of the succession planning for the nursing team and a ward-based Matron has been seconded to support the ward. Two new Macmillan Nurses have also been appointed.

SECTION B – Local

CCG Mergers: NHS England has recently approved a first tranche of Clinical Commissioning Group (CCG) mergers for April 2020 but has yet to confirm or publish details. However, a number of CCGs have confirmed to the Health Service Journal (HSJ) that their merger applications were successful and the HSJ has reported that Eastern Cheshire CCG, South Cheshire CCG, Vale Royal CCG and West Cheshire CCG will be merging. It is anticipated that CCG mergers will improve efficiency and generate savings and the Accountable Officer for the Cheshire CCGs was quoted as saying that the merger "will enable us to strengthen our work as a single team to ensure the people of Cheshire are able to access consistently good care- wherever they live".

SECTION C – National

BREXIT: The date for EU exit remains uncertain following the granting of a 'flextension' to 31 January 2020. The EU Exit SRO remains as the Director of Finance with subject matter experts available for critical areas such as procurement, pharmacy and estates. The business continuity plans continue to be led by the Trust's Emergency Preparedness lead.

The last readiness assessment did not raise any significant concerns however the Trust will continue to engage with the National and Local teams to ensure that any potential impact to the Trust is minimised, and respond to guidance as and when it is issued.

NHS Providers Board of Trustees: NHS Providers has announced the results of recent elections for its Board of Trustees with the following candidates being elected to the Board for 3-year terms:

- Lance McCarthy, Princess Alexandra Hospital NHS Trust
- Brent Kilmurray, Bradford District Care NHS Foundation Trust
- Beatrice Fraenkel, Mersey Care NHS Foundation Trust

As of 1 November 2019, the composition of the newly constituted Board is as follows:

Acute Trust Chairs	Trust	End of term
Suzy Brain England	Doncaster & Bassetlaw Teaching Hospitals NHS FT	June 2020
Hattie Llewelyn-Davies	Buckinghamshire Healthcare NHS Trust	June 2020
Chris Outram	The Christie NHS FT	June 2022
Linda Pollard	Leeds Teaching Hospitals NHS Trust	June 2022
Karamjit Singh	University Hospitals of Leicester NHS Trust	June 2022
Acute Trust CEs	**Trust**	**End of term**
Daniel Elkeles	Epsom & St Helier University Hospitals NHS Trust	June 2022
Nick Hulme	East Suffolk and North Essex NHS FT	June 2021
Lance McCarthy	Princess Alexandra Hospital NHS Trust	June 2022
Patricia Miller	Dorset County Hospital NHS FT	June 2022
Tracy Taylor	Nottingham University Hospitals NHS Trust	June 2021
Mental Health Trust Chairs	**Trust**	**End of term**
Dean Fathers	Nottinghamshire Healthcare NHS FT	June 2021
Beatrice Fraenkel	Mersey Care NHS FT	June 2022
Jagtar Singh	Coventry & Warwickshire Partnership Trust	June 2020
Mental Health Trust CEs	**Trust**	**End of term**
Angela Hillery	Northamptonshire Healthcare NHS FT	June 2020
Brent Kilmurray	Bradford District Care NHS Foundation Trust	June 2022
Melanie Walker	Devon Partnership NHS Trust	June 2021
Ambulance Trust Chair	**Trust**	**End of term**
Heather Lawrence	London Ambulance Service NHS Trust	June 2022
Ambulance Trust CE	**Trust**	**End of term**

Will Hancock	South Central Ambulance Service NHS FT	June 2020
Community Trust Chair	Trust	End of term
Ingrid Barker	Gloucestershire Care Services NHS Trust	June 2021
Community Trust CE	Trust	End of term
Colin Scales	Bridgewater Community Healthcare NHS FT	June 2020
Co-opted		End of term
Alan Foster		Dec 2019
Chair		Appointed
Dame Gill Morgan	NHS Providers	January 2014

Independent Review of Adult Screening Programmes in England: On 16 October 2019 NHS England published a report written by Professor Sir Mike Richards. The report assesses current screening practices and makes a series of recommendations on updating national programmes, with new technology and developments offering opportunities to improve uptake and ultimately save lives through early diagnosis of key health conditions. The NHS Long Term Plan includes a goal of saving an extra 55,000 lives each year within a decade by catching three quarters of all cancers early. The report outlines 22 recommendations towards achieving that goal. A copy of the full report is available through the following link:

https://www.england.nhs.uk/publication/terms-of-reference-review-national-cancer-screening-programmes-england/

Attach to CEO Report Flu Campaign

Liverpool Women's NHS Foundation Trust

Agenda Item	2019/165a

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Flu Campaign Update & Self Assessment**
DATE OF MEETING:	Thursday, 07 November 2019
ACTION REQUIRED	**Approve**
EXECUTIVE DIRECTOR:	Michelle Turner, Director of Workforce and Marketing
AUTHOR(S):	Simon Davies – HR Manager
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☐ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ ***RESPONSIVE –*** *the services meet people's needs.* ☒ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS*** ☐

Liverpool Women's NHS Foundation Trust

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution **2.** Operational Plan **3.** NHS Compliance	☐ ☐ ☒	**4.** NHS Constitution **5.** Equality and Diversity ***6.*** Other:	☐ ☐
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board / Committee is asked to:-….)***	***The Board are asked to approve the self-assessment included in this paper.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Not Applicable	
	Date of meeting			

Executive Summary

The 2019/2020 flu vaccination campaign is now underway. This years' CQUIN target has increased to 80% of frontline clinical staff, although the Trust aspires to vaccinating all frontline clinical staff. Currently 34.2% of frontline staff have been vaccinated. Current stocks of vaccines have been exhausted although a further delivery is due on 8th November, allowing the campaign to re-start on 11th November. The self-assessment checklist provided by NHS England has been completed and is attached as appendix 1.

Report

1) Introduction

The purpose of this paper is to give assurance that this years' flu vaccination campaign has been planned and underway, and ask the committee to endorse the completed self-assessment requested by NHS England in their letter of 17th September 2019 to the Chair and Chief Executive. Also included, is a review of last year's flu vaccination campaign.

2) Review of 2018/19 Flu Vaccination Campaign

For 2018/19 the annual flu vaccination campaign was undertaken from 8th October 2018, with vaccines being available until February 2019. The campaign was delivered by the Occupational Health & Wellbeing team from Aintree University Hospitals NHS Trust (now part of Liverpool University Hospitals NHS Foundation Trust) who are our occupational health services provider. They provided drop in sessions open to all staff, targeted visits to specific departments (including night staff) and attended various meetings and training sessions to ensure that the opportunities for staff to be vaccinated was maximised.

The table below shows the final figures for the number of staff vaccinated:

staff group	medical	nursing & midwifery	allied health professionals	support	totals
staff eligable to be vaccinated	73	604	33	223	933
actual number vaccinated	71	424	33	190	718
percentage vaccinated	97.3%	70.2%	100.0%	85.2%	77.0%

as well as the above frontline staff for who vaccination is required, a further 145 no frontline staff were also vaccinated

The 2018/19 CQUIN target of vaccinating at least 75% of frontline staff was met.

Reviewing the 2018/19 flu campaign, the positive aspects were:

- CQUIN target was reached
- The campaign was very visible throughout the Trust
- Support and buy-in from the senior nursing & midwifery team and from the Trust Board
- We worked well with our Occupational Health providers at Aintree who actually carried out the vaccinations
- We also managed to vaccinate a lot of non-frontline and corporate staff

Issues that were more challenging and need to be addressed in the 2019/20 campaign:

- Difficulties in engaging with community based staff
- Not enough peer vaccinators to support in those areas where it was harder for the Occ Health team to engage with staff, eg) community based staff and those on nights and weekends

3) 2019/20 Flu Vaccination Campaign

This year's campaign began on 7th October 2019. Although the final submission of the uptake figures has to be completed by 31st December 2019, vaccinations will still be available up until the end of February 2020. This year, the CQUIN target has increased to 80% of frontline clinical staff, although the aspiration is to vaccinate 100%.

As was the case last year, the vaccination program is being delivered by our occupational health provider. A program of targeted visits and drop in sessions has been drawn up and publicised. Learning from last years' experience, a number of senior nursing and midwifery staff (including some in community based services) are being trained in November to administer vaccinations to staff.

There has however been a nationwide shortage of vaccines so that the vaccines ordered are only being delivered in stages. To date, the first two batches of vaccines have been received with the third delivery due on 8th November. So far, 34.2% of frontline staff have been vaccinated, but we have now exhausted the current supply of vaccines. The vaccination campaign will be restarted on 11th November 2019, following the final delivery of vaccines on 8th November 2019.

Appendix 1 is the completed self-assessment checklist provided by NHS England for public assurance via the Trust Board.

4) Recommendations

The committee are asked to accept the assurance given in the report and endorse the completed self-assessment. The committee are also asked to endorse the aspiration target to vaccinate 100% of frontline clinical staff.

Appendix 1 – Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2019

A	Committed leadership (number in brackets relates to references listed below the table)	Trust self-assessment
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	included in this paper – when occ health visit clinical areas to administer vaccinations, they do ask those who decline them to complete a slip giving their reasons (but not compulsory)
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers.	completed
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt.	included in this paper
A4	Agree on a board champion for flu campaign.	Michelle Turner – Director of Workforce & Marketing
A5	All board members receive flu vaccination and publicise this.	occ health scheduled to attend November & December board meetings
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives.	virtual group has been set up with divisional triumvirates and staff side to share information and exchange ideas
A7	Flu team to meet regularly from September 2019.	weekly e-mail updates
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions.	comms published giving rationale for the vaccination programme – sponsored by MD, DoN and Staff Side Chair
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper.	completed
B3	Board and senior managers having their vaccinations to be publicised.	photo of board members being vaccinated to be included in comms following board meeting
B4	Flu vaccination programme and access to vaccination on induction programmes.	completed
B5	Programme to be publicised on screensavers, posters and social media.	on-going
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups.	regular updates circulated to senior management teams and included in weekly comms bulletin
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered.	scheduled for wb. 11th November
C2	Schedule for easy access drop in clinics agreed.	completed
C3	Schedule for 24 hour mobile vaccinations to be agreed.	sessions for night staff included in the schedules

D	Incentives	
D1	Board to agree on incentives and how to publicise this.	staff vaccinated receive a flu fighters pen and sticker
D2	Success to be celebrated weekly.	regular updates included in weekly comms bulletin

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Quality Committee meeting held 23 September 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. The Committee noted that the Board Assurance risks are now being populated onto the existing Ulysses system. As a result, the BAF report will be produced in a new format and will be developed over the next few months. The Committee was assured by the assurance provided.

~ Subcommittee Chairs reports: The Committee received a chairs report from the Safety Senate, Effectiveness Senate and a verbal update from Corporate Risk Committee. The Committee considered issues raised in relation to pathology and Liverpool Clinical Laboratories and requested an assurance report to be presented to the next meeting. There were no new risks escalated to the Committee for review.

~ Adult Mortality and Perinatal Q1 Report: The Committee was assured by progress being made and that there are no themes identifying cause for concern with either adult or perinatal mortality. Concern was raised in relation to rates of Neonatal mortality in Liverpool compared to similar Trusts in the Northwest. The data is being reviewed and a verbal update would be provided to the next Quality Committee in October.

~ CQC Inspection Action Plan: The Committee received assurance on the progress being made against the CQC inspection action plan. It was noted that the Trust had received their Provider Information Return (PIR) request from CQC, with a required submission date of 3rd October 2019.

~ EPR Update: The Committee received a verbal update. An assurance paper with regards to EPR and associated risks would be circulated to Committee members.

~ Monthly Quality Performance Review M5 2019/20: The Committee received an update on Operational Performance at Month 5 2019/20. The Committee noted that challenges continued in achieving Cancer and RTT targets, however the trajectories that were agreed in June were reached in August, with a view to hit the target of 92% in summer 2020. It was noted that the improvement in performance coincides with the number of patient pathways.

~ Quality Spot Checks Audit – Gynaecology and Bedford: The Committee noted that Mersey Internal Audit Agency had completed the audit reviews in Gynaecology and Bedford. The Committee agreed that all actions had been managed appropriately and commended the division.

~ LocSIPPs Assurance Report: The Committee noted that Mersey Internal Audit Agency had completed its audit and had provided moderately assurance.

NHS

- **Clinical Audit Annual Report 2018/19:** The Committee noted the annual report and was assured that significant progress is being made with the Clinical Audit Programme.

- **Clinical Case for Change Mitigations and Counterfactual Case:** The Committee received a verbal update detailing clinical sustainability. The Committee agreed that it would be beneficial to receive a monthly update to identify potential risks from a quality perspective.

3. **Board Assurance Framework (BAF) risks reviewed**
   No new risks identified. No changes to existing risks identified, noting that one may be proposed in the future relating to Maternal Medicine.

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

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

6. **Action required by Board**
   None

Susan Milner
Chair of Quality Committee
September 2019

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Quality Committee meeting held 21 October 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. The Committee endorsed a revised approach to Risk ID 2184 (EPR) and noted the preparation of three new risk entries for inclusion on the Board Assurance Framework in November 2019. The proposed new entries, which relate to; Seven Day Services, Networked Maternal Medicine and Gynaecology Oncology Consultants, will be considered by the Committee at its next meeting on 25 November 2019.

~ Subcommittee Chairs reports: The Committee received Chair's Reports from the Effectiveness Senate, the Experience Senate and the Corporate Risk Committee. The Committee noted work on a draft Quality Strategy by the Effectiveness Senate and requested a report on progress at the next Committee meeting on 25 November 2019. There were no new risks escalated to the Committee for review.

~ Quality and Regulatory Update: The Director of Nursing & Midwifery presented a report which provided assurance on both progress against outstanding actions from the 2018 Care Quality Commission (CQC) inspection and preparation for the 2019 inspection. The Committee noted that the Provider Information Request (PIR) had been submitted by the deadline of 3 October 2019 and reviewed the Quality Statement included in the PIR.

~ Safeguarding Annual Report 2018/19: Mrs M McDonough, Associate Director Nursing & Midwifery for Safeguarding, joined the meeting to present the Safeguarding Annual Report 2018/19. The Committee noted that a significant amount of work had been undertaken in this area during the year and was assured that actions taken to address Safeguarding training requirements had resulted in improved performance in 2019/20. The Committee recommended the Safeguarding Annual Report 2018/19 to the Board of Directors for approval.

~ Seven Day Services Report: The Committee received a report which detailed performance against the four priority standards for Seven Day Services together with an update on status for the non-priority standards. The Committee noted that the Trust is currently meeting just one of the four priority standards but acknowledged that performance in the three non-compliant areas is impacted by the nature of the patient cohort and/or the situation set out in the Future Generations strategy.

NHS

- **Clinical Case for Change Mitigations and Counterfactual Case:** The Committee received a verbal brief from the Medical Director on matters relating to the Clinical Case for Change which detailed subjects discussed during a meeting held with the North West Region Medical Director on 17 October 2019. These included discussion on the on-site developments which would be necessary to ensure clinical safety in the short to medium term. The Committee was also advised of progress with the development of a Memorandum of Understanding with Liverpool University Hospitals NHS Foundation Trust to establish a Partnership Board for the management of risks associated cross-site working. The Committee noted the briefing and requested that formal reports be provided for this standing agenda item at future meetings.

- **Monthly Quality Performance Review M5 2019/20:** The Committee received an update on Operational Performance at Month 5 2019/20 which also included unvalidated data for Month 6. The Committee noted that, while improvement against the Referral to Treatment (RTT) 92% standard had been sustained in September 2019, performance against the Cancer standards continues to be particularly challenging. The Director of Operations briefed the Committee on the actions being taken to address capacity and demand issues but the Board should be aware that these are not expected to result in a material improvement in performance in the short term.

- **Pathology Update Report:** The Director of Operations presented a report which detailed contract performance for pathology services provided by Liverpool Clinical Laboratories (LCL). The Committee received the report and noted a specific risk relating to Histopathology which is being managed by the Pathology Steering Group. The Committee acknowledged the need to address the performance issues set out in the report and approved commencement of appropriate procurement processes.

- **Annual Reports 2018/19:** The Committee received and noted the following reports:

    - Security Management Annual Report 2018/19
    - Legal Services Annual Report 2018/19

- **Neonatal Mortality:** The Deputy Medical Director provided a verbal briefing on matters raised at the previous meeting in advance of a written report at the next meeting on 25 November 2019. The Committee was assured that all instances of Neonatal Mortality are subject to comprehensive review.

- **Serious Incidents Report:** The Committee considered a report that detailed Serious Incidents for Quarter 2 2019/20. The Committee noted that 5 serious incidents had been reported during the period, which included a Never Event that occurred in September 2019. The Committee was assured that Duty of Candour had been completed for each of the 5 incidents. The Committee queried the presentation of the report, in relation to the level of assurance provided on learning from incidents, and agreed that future reports should include appropriate contextual narrative.

3. **Board Assurance Framework (BAF) risks reviewed**

The Board should note that a number of new risks, as detailed above, will be presented for approval at the Board of Directors meeting on 5 December 2019.

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

5. Issues to highlight to Board
   None.

6. Action required by Board
   None

Susan Milner
Chair of Quality Committee
23 October 2019

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 23 September 2019

1. Was the quorate met? Yes

2. Agenda items covered

~ **Operational Performance Month 5 2019/20 including RTT and Cancer Targets:** The Committee received an update on Operational Performance as at Month 5 2019/20 which included a presentation on the Referral to Treatment (RTT) recovery trajectory. The Committee noted improved RTT performance from Month 4 and progress towards achievement of the 92% standard by the summer of 2020. In reviewing RTT and Cancer performance, and in response to a request from the Committee, the Director of Operations agreed to include both validated data and the most recent unvalidated data in future reports.

~ **Finance Performance Review Month 5 2019/20 including CIP:** The Committee received a report on the Month 5 finance position noting that, as at 31 August 2019, the Trust was reporting a deficit position of £0.8m against a planned position of £0.9m and a favourable variance of £0.1m. The Trust continues to forecast delivery of the breakeven control total, incorporating central funding of £4.6m, with a current outturn forecast of a £0.2m surplus. The Committee noted that the position at Month 5 was based on a full forecast, with the forecast signed off by each clinical division, which provided a greater degree of assurance in relation to control total delivery. However, the Committee also noted that the overall position included a forecast overspend of circa £2.8m for the Gynaecology Division, largely as a result of challenges in the recruitment of substantive consultants and consultant turnover which has impaired activity and income. This situation has also impacted the Trust's performance against the agency cap and is a matter which will be subject to continued close scrutiny by the Committee. With regard to the cost improvement programme, performance remains positive and on plan, with any emergent risks being managed and mitigated through the application of robust grip and control measures. The Trust's cash position has reduced and stabilised following repayment of historic deficit loans with a value of £6.6m in August 2019. The position remains positive with a cash balance of £6.2m at 31 August 2019, some £1.6m ahead of plan. However, the Committee noted that capital expenditure was circa £3.5m behind plan at Month 5 but was assured that expenditure relating to medical equipment and the Neonatal development had been deferred until later in the year.

~ **Oversight Framework and Long-Term Plan:** The Committee was briefed by the Director of Finance on the principles of a single Oversight Framework, which was published by NHS Improvement / NHS England in August 2019 and provides for closer alignment between the Oversight Framework and the CQC assessment process. Providers are allocated to a 'segment' and the Committee noted that the Trust is currently in Segment 3 i.e. *'The provider has significant support needs and is in actual or suspected breach of the licence but is not in special measures.* With regard to the Long-Term Plan, the Committee was assured that the Trust had submitted a draft plan to the STP on 13 September 2019 and was briefed on the detailed work completed to date in preparation of the draft plan. The Committee was advised by the Director of Finance of the further work required to develop the draft plan for the next submission in November 2019. The Committee was assured that plans are in place to ensure timely completion of this work.

- **Strategic Outline Case**: The Committee received a verbal briefing from the Director of Finance and noted the recent establishment of a weekly Future Generations Project Board. The Committee was also advised of the Trust's participation as a case study in a programme being coordinated by NHS Providers regarding capital planning.

- **Neonatal Build Update:** The Committee received an assurance report from the Director of Finance which detailed progress against the Neonatal Build project plan. The Committee noted that the project was 50 weeks into a planned 97-week construction programme and was advised of a revised completion date of 10 August 2020. This 2-3 week slippage resulted from a delay in the appointment of preferred contractors and the Committee noted that mitigating actions had reduced the delay from 7 weeks to the current 2-3 weeks. The Committee was assured that Interserve, the prime contractor, is committed to recovering the original completion date over the remainder of the programme. No concerns were escalated in relation to operational progress and the Committee was assured that relationships between Trust staff and Contractor staff remain positive.

- **IM&T Reports:** The Committee received a number of IM&T-related reports and noted that the Global Digital Exemplar (GDE) programme was progressing well with the Trust expecting to achieve all requirements within the agreed timescales. Completion of the requirements will secure related capital funding of circa £1.2m in 2019/20. The Director of Finance presented an assurance report on actions relating to information systems included in the post-CQC inspection action plan in the context of the Trust's Electronic Patient Record (EPR) programme. The Committee was briefed on the current position of the EPR programme and noted the mitigating measures being taken to address actions relating to; multiple systems, IT infrastructure and enhancement of information systems.

- **Brexit Update**: The Committee noted the continuing uncertainty on Brexit arrangements but was assured that the Trust remains responsive to local and national guidance on this subject.

- **Annual Estates Return Information Collection (ERIC) 2018/19:** The Committee received a report from the Director of Finance that detailed the ERIC submission for 2018/19. The Committee acknowledged the submission and was assured that effective management and monitoring of the Trust's estate is in place.

- **Emergency Preparedness Resilience & Response (EPRR) Annual Report:** The Committee received and noted the EPRR Annual Report 2018/19 which provided a summary of EPRR activities and achievements during the 12-month period. The Committee noted that the Trust has a portfolio of emergency plans which are subject to regular periodic review.

- **National Cost Collection Update:** The Committee considered and approved the final submission report, having reviewed the draft submission on 24 June 2019. The Committee noted that the Trust's Reference Cost Index will be published in November 2019 and the likelihood that a small increase in costs and a reduction in overall activity will result in a higher RCI than the index of 102 for 2017/18.

- **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:**
  - Information Governance Sub-Committee.

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 –note RTT and Cancer referred above.

5. Issues to highlight to Board
   None

6. Action required by Board
   No actions required.

Jo Moore
Chair of the Meeting – FPBD, September 2019

Board of Directors

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

1. Was the quorate met? Yes

2. Agenda items covered

~ **Operational Performance Month 6 2019/20 including RTT and Cancer Targets:** The Committee received a report on Operational Performance as at Month 6 2019/20 and noted continued improvement in RTT performance against the 92% standard with unvalidated performance of 82.84% in September 2019. The Trust's improvement trajectory continues to aim for achievement of the 92% standard by the summer of 2020. The Committee noted that performance against the cancer standards remains challenging. While the standard for Two Week Waits was achieved, performance against both the 31 Day and 62 Day indicators fell far short of the required standards.

~ **Finance Performance Review Month 5 2019/20 including CIP:** The Committee received a report on the Month 6 finance position noting that, as at 30 September 2019, the Trust was reporting a deficit position of £1m against a planned position of £1.2m and a favourable variance of £0.2m. The Trust continues to forecast delivery of the breakeven control total. The Committee was assured of continued strong performance against the cost improvement programme in Month 6 and the programme remains on track for full delivery in 2019/20. In reviewing contract performance, the Committee noted year to date under-activity for the Maternity, Gynaecology and Hewitt Directorates and an overall negative contract variance of 5.7%. The Committee was advised of a potential financial consequence of circa £500k should the level of variance continue. The Committee was also advised of the risk that the Trust will exceed the Agency Cap ceiling for 2019/20 with expenditure of £965k against a year to date cap figure of £745k. The Committee noted the implications of exceeding the ceiling on both the financial position and the Trust's Use of Resources risk rating. Contract performance and agency expenditure will be subject to continued close scrutiny by the Committee.

~ **Operational Plan – 6 Monthly Review:** The Committee received an assurance report from the Director of Operations which detailed progress against the Operational Plan 2019/20. The Committee took positive assurance from the report and noted good progress made across all elements of the Plan with the exception of performance against the Cancer standards.

~ **Cost Improvement Programme 2019/20 – Mid-Year Post Implementation Review:** The Director of Finance presented a report which detailed outcomes from a mid-year post implementation review of the cost improvement programme. The Committee took positive assurance from the outcomes of the review which monitors the qualitative impact of the individual schemes within the programme. This best practice approach identified both positive impacts on quality and a small number of adverse impacts, such as, canteen opening times, car park barrier functionality and short-term impact of a Finance department restructure. Management teams will seek to identify means of mitigating adverse impacts.

~ **Strategic Outline Case:** The Committee received a verbal briefing from the Medical Director on matters discussed during a meeting with the North West Region Medical Director held on 17 October 2019 and noted that the discussion had focused on the key clinical risks facing the

Trust and means of mitigation. The Committee was also briefed by the Chief Executive on recent media coverage relating to the Future Generations strategy.

~ **Long-Term Plan Update:** The Committee considered a report regarding preparation of financial, activity and workforce plans to support implementation of the NHS Long Term Plan. The Committee noted the significant work completed to date in short timescales to prepare plans for submission to the Cheshire & Mersey STP by 1 November 2019. The Committee acknowledged that work will continue to refine the plan content set out in the report but recommended plan content to the Board of Directors for approval.

~ **Treasury Management Quarter 2 Report:** The Deputy Director of Finance presented a report which detailed the Quarter 2 position on; Cashflow, Loans, Aged Debt and Better Payment Practice Code (BPPC) performance. The Committee considered the report and noted in particular a Cash Balance Forecast included as an Appendix to the report. The Committee also noted the Trust's plans for drawdown of capital funding and repayment of the balance (£6.7m) of a Department of Health loan in August 2019.

~ **Neonatal Build Update:** The Committee received a report from the Director of Finance on progress with the Neonatal Build and agreed that the report provided positive assurance on progress. The Committee noted that the forecast completion date of 10 August 2020 had not changed since the previous month with the potential that the 2-3 week slippage included in this date may be recovered over the remainder of the programme. The Committee was assured that relationships with the prime contractor remain positive.

~ **Liverpool Neonatal Partnership:** The Director of Operations presented a report which provided an update on the Liverpool Neonatal Partnership and included a draft updated Memorandum of Understanding (MoU) between the Trust and Alder Hey Children's NHS Foundation Trust. The Committee noted the report and provided a view on the content of the draft MoU. The Committee noted that, while a funding gap for the service had been partially mitigated, there remained a need to address the residual gap and the Director of Operations provided an update on recent engagement with Specialist Commissioning colleagues on this matter.

~ **Communications, Marketing and Engagement Strategy 2016-20:** Mr A Duggan, Head of Communications, joined the meeting and presented a report that provided the Committee with positive assurance on progress with delivery of the current Communications, Marketing and Engagement Strategy. The Committee was advised of work to prepare a new Strategy for 2020-25 and noted that Board members would have the opportunity to participate in development of the new Strategy.

~ **Information Governance Update:** The Committee received a report from the Director of Finance which detailed progress with the implementation of new Information Governance arrangements following the introduction of a new Data Security and Protection Toolkit. The Committee noted both the progress made with implementation of arrangements and initiatives to strengthen areas of compliance with the new Toolkit.

~ **Brexit Update**: The Committee noted the continuing uncertainty on Brexit arrangements but was assured that the Trust remains responsive to local and national guidance on this subject.

- **Board Assurance Framework:** The Committee reviewed the risks 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:**
  - Emergency Preparedness, Resilience and Response Committee.
  - Digital Hospital Committee (verbal)

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 –note RTT and Cancer referred above.

5. **Issues to highlight to Board**
   The Committee confirmed its recommendation to approve a Paper Free Business Case which had been subject to virtual consideration by the Committee during week commencing 14 October 2019. The Business Case will subsequently be presented to the Board of Directors for approval

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

Jo Moore
Chair of FPBD Committee
22 October 2019

Liverpool Women's NHS Foundation Trust

Board of Directors

Chair's report of Putting People First Committee meeting held on 23 September 2019

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

2. **Agenda items covered**

- Review of Board Assurance People Risks

- **Clinical Support Services Review –** This Division was formally established in April 2019, bringing together previously separate services – Genetics, Surgical Services, Integrated Administration, Imaging, Pharmacy and Physiotherapy. A number of significant and service changes in this time were highlighted, including Genetics Laboratory Service Transfer to MFT, the extension of the 100k Genome Project, the establishment of the Resus training team and the renaming of the service to become the Liverpool Centre for Genomic Medicine. KPI's were reviewed in detail – LTO and Absence both tracking above trust targets. PDR and mandatory training are also below target, but showing an improving trend. Some discussion on recruitment – intense focus on physio recruitment has shown dividend, but theatre recruitment remains a challenge.

- **Director of Workforce Report** – Update on PPF Strategy; Summer of Listening now drawn to a close; OLM project showing positive outputs; MT audit disappointing, but clear action plan in place; NHS Graduate Trainee in Operational Management has now joined the Trust; On track to meet HEE targets for widening participation; Successful in bid to become an early adopted of NHS Leadership Academy Talent Management Programme; Health & Welling activities update; Update on pensions consultation.

- **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. Revised format of report was deemed to be an improvement and would be adopted going forward.

- **Leadership Development Programme Review** – Assurance was provided that the Leadership Programme remains in place and gains positive review from those who attend. Attention was drawn to the challenges with attendance – senior teams will be asked to renew support and ensure attendance wherever possible.

- **Medical Appraisal and Re**-validation Annual Report – The Committee received the annual report providing assurance that the trust is performing well, whilst understanding that improvement is required to manager doctors who do not seek approval for late/incomplete appraisals.

- **Nurse and Midwife Revalidation & Registration** – Revalidation was introduced by the NMC in April 2016. Nurses and midwives are required to re-validate after 3 years. Registration renewal is annual. The Committee noted that the Trust has a professional registration and revalidation policy in place which applies to all relevant staff, including bank workers.

NHS

In 2019 no lapses in registration/revalidation have been noted. The Committee agreed that further updates will form part of the Bi-Annual Staffing Paper to ensure regular oversight.

- **Nursing, Midwifery & AHP Strategy** – The strategy was presented for approval. Clear feedback was offered in relation to the structure of the document, differentiating between the strategic aims and the action plan for delivery of those aims. Further work to be undertaken and the amended version circulated on email for approval.

- **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. Limited discussion in relation to the Freedom to Speak Up Vision and Strategy.

- **Mandatory Training Audit** – Outcome – The Committee received the outcome from the May 2019 Mandatory Training Audit completed by MIAA. The Trust achieved "Limited Assurance". Specific focus areas were discussed – OLM accuracy, Trust oversight & reporting, Bank workers, Volunteers - and the Committee received assurance that an action plan was in place with a number of items already completed.

- **Outsourced Service Contract Review** – The Committee received an update on the current outsourced service arrangements, and supported the recommendations to continue with those services.

- **Sickness Absence Management Report** – The Committee received an in depth report on the levels of sickness absence across the Trust. Assurance was provided that all areas clearly understand the level and reasons for absence, and how this compares to other Trusts and external benchmarks. Further information was requested in relation to practical steps and in plans in place to reverse the upward trend.

- **EDS2** – this paper was not discussed and will transfer to the November agenda.

- **Policies for approval** – Following policies approved:
  - Organisation Change, Pay Protection & Redundancy Policy
  - Redeployment Policy
  - Retirement Policy
  - Special Leave Policy
  - Job Planning for Consultant Nurses and Midwives
  - Annual Leave Policy
  - Secondments & Acting Up Policy
  - Dignity at Work Policy
  - Policy for Supervision and Assessing Competence of Medical Staff In Training

- Removal and Related Expenses for Consultant Medical Staff SOP
- Anti-Fraud & Bribery Policy

- **Sub Committee Reports** – The following sub Committee Reports were received.
  - Diversity & Inclusion
  - Education Governance
  - Sickness Improvement Project
  - Health & Wellbeing
  - Partnership Forum
  - NHSI Retention

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

To raise with the Board the KPI compliance around Mandatory Training.

AUTHOR NAME Tony Okotie

DATE 23 September 2019

Board of Directors
Committee Chair's report of Audit Committee meeting held 21 October 2019

1. Meeting Quorate: Yes

2. Agenda items covered

~ **Minutes of Meeting:** The Minutes of the previous meeting held on 22 July 2019 were agreed as a true and accurate record.

~ **Follow up of Internal Audit and External Audit Recommendations:** The Committee received an updated position on audit recommendations, noting that there were no overdue outstanding actions. The Committee noted that there were thirteen outstanding actions that were not due for completion and was assured that actions were being implemented and followed up in a timely manner.

~ **Internal Audit Progress Reports:** The Committee received a report which detailed outcomes of Internal Audit Reviews as follows:

- Implementation of Baby Tagging System – Moderate Assurance
- Safety Standards for Invasive Procedures 2018/19 – Moderate Assurance
- Patient Kiosk IT Critical Application Review – Moderate Assurance
- Mandatory Training – Limited Assurance
- Job Planning (Consultants) – Not Assessed (Briefing Note Report)
- Key Financial Systems – See Below

The audit reviews on Key Financial Systems covered: General Ledger, Budgetary Control, Treasury Management, Accounts Payable and Accounts Receivable. Each of the reviews resulted in an assessment of either High Assurance or Substantial Assurance. The Committee was assured that management actions had been agreed to address recommendations arising from audit reviews. The Committee noted the Limited Assurance assessment for the Mandatory Training review and requested that the Director of Workforce & Marketing provide an assurance report on progress against recommendations at the next Committee meeting on 27 January 2019.

~ **Anti-Fraud Progress Report:** The Committee considered a report from the Trust's Anti-Fraud Specialist (AFS) and the Committee was assured that good progress is being made against the 2019/20 Anti-Fraud Plan. The AFS briefed the Committee on the status of two current investigations, both of which relate to allegations of false representation.

~ **KMPG Health Sector Technical Update Update:** The Committee received a Health Sector Technical Update from the External Audit Manager that highlighted issues relating to the health sector which included; National Audit Office consultation on a new Code of Audit Practice, New Hospital Building Programme, Freedom to Speak Up guidance and NHS

Oversight Framework 2019/20. The Committee noted that there were no specific updates for action by the Trust.

~ **Waiver Report Quarter Two 2019/20:** The Committee received the Waiver Report for Quarter Two 2019/20 and noted that there had been 15 instances where Standing Financial Instructions (SFI) had been waived during the period. The Committee noted that this represented a positive reduction in both number and value of Waivers from the Quarter One position and was assured by the information provided by the Director of Finance on the process and controls in place relating to Waiver Requests.

~ **Integrated Governance Assurance Processes:** The Interim Trust Secretary presented a report which detailed the range of governance processes in place to provide assurance on the effectiveness of internal control arrangements. The Committee took positive assurance from the report and noted in particular the independent assurance on effectiveness provided by a positive Head of Audit Opinion published in May 2019.

~ **Clinical Audit Annual Report:** The Committee received and noted the Clinical Audit Annual Report 2018/19. In considering the report, the Committee agreed that respective roles of the Audit Committee and Quality Committee in relation to Clinical Audit should be clarified to ensure appropriate reporting. The Committee agreed that the Interim Trust Secretary, Director of Finance and Medical Director would consider this matter.

~ **Charitable Funds Transactional Processes:** The Committee received a comprehensive report from the Director of Finance on the financial governance and controls relating to the Trust's Charitable Funds. The report had been requested by the Committee at its previous meeting and the Committee welcomed the positive assurance provided on the Charitable Funds arrangements. The Committee suggested that the report should also be presented at the next Charitable Funds Committee meeting.

~ **Chairs Reports**: The Committee received and reviewed the Chairs reports for recent meetings of the Finance Performance and Business Development Committee and Quality Committee and noted that the committees were working effectively with no areas of concerns regarding the processes and procedures in place to support the committees' work.

3. Board Assurance Framework (BAF) risks reviewed
   ~ **Board Assurance Framework:** The Committee was assured of the processes in place to review the Board Assurance Framework.

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

5. Escalation to Other Committees
   ~ None

6. Issues to highlight to Board
   ~ **Memorandum of Understanding between Cheshire & Merseyside Health & Care Partnership and Mersey Internal Audit Agency (MIAA):** The Committee received a briefing from the Internal Audit Manager on the development and aims of the Memorandum of Understanding (MoU) with a specific aim to deliver improvements in the quality, resilience and cost-effectiveness of Internal Audit services across Cheshire & Merseyside. The participation of all Partnership members in the MoU is being sought. The Committee subsequently discussed

the Trust's participation, without audit representatives present, and considered the arrangements in the context of both collaborative working and retention of Trust control over individual contract arrangements. Following due deliberation, the Committee agreed that the Director of Finance should progress the Trust's participation.

7. Action required by Board
   ~ None.

Ian Knight
Chair of Audit Committee
22 October 2019

Liverpool Women's NHS Foundation Trust

	Agenda Item **2019/170**
MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Clinical Summit Outcomes**
DATE OF MEETING:	Thursday, 07 November 2019
ACTION REQUIRED	**Receive**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Andrew Loughney, Medical Director
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☐ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE****- People are protected from abuse and harm* ☒ ***EFFECTIVE*** *- people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING*** *- the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE*** *– the services meet people's needs.* ☒ ***WELL-LED*** *- the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care,* ☐

	supports learning and innovation, and promotes an open and fair culture. ***ALL DOMAINS*** ☐	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☐	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to note the report and provide support for: • The establishment of LWH as an MMC subcentre • The further development of partnership working with LUH • The principles behind a review of recruitment and retention for senior medical staff.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable
	Date of meeting	

Executive Summary

In June 2019, a Clinical Summit was held at Liverpool Women's Hospital, which was attended by around one hundred delegates drawn from a range of provider organisations in Cheshire and Merseyside, commissioners, NHSE/I, the CQC and the Critical Care Network. A range of topics was presented and discussed. This paper sets out some of the background relating to three of those topics:

- Networked Maternal Medicine Services
- Gynaecological Oncology
- The Age Profile of Consultant at LWH

In each case, an update is now provided on the work carried out to date, which is aimed at reducing the clinical risks identified in the short to medium term. The closely related issues of recruitment and retention and the workings of a proposed Partnership Board with Liverpool University Hospitals NHS FT are also included.

Report

Introduction

Liverpool Women's NHS FT (LWH) has previously set out the challenges it faces in delivering the highest quality of healthcare on its isolated Crown Street site. Clinicians at LWH have concluded that to sustain the services of the trust into the future, relocation onto an adult acute site would be required. These conclusions have been articulated in the trust's Future Generations strategy, confirmed through a rigorous options appraisal process run by Liverpool CCG and supported in a Clinical Senate report from independent experts under the umbrella of NHSE.

To date, the DHSC has not given the trust permission to raise the capital required for the construction of a new hospital. Even if this was now achieved, services will continue to be run from the Crown Street site for several years to come. Given these facts, it is important that the trust revisits its clinical position periodically so that relevant and up to date information firstly can be used internally to counteract the clinical threat and secondly can be shared externally so that the need for relocation remains a visible priority for the system. To this end, a Clinical Summit was held in the Trust on 11th June 2019, to which all key stakeholders were invited and at which, a set of key clinical questions was asked.

Six distinct workstreams were identified following the Clinical Summit and an action plan has been created to match these workstreams. Progress against the action plan is driven by a Task and Finish Group, which meets fortnightly and consists of the Medical Director, Clinical Directors, the Chair of the Medical Staff Committee, operational leads and Heads of Nursing and Midwifery. This paper provides the Board with an update on progress against three priority areas: Network Maternal Medicine Services, Gynaecological Oncology and The Age Profile of Consultant Medical Staff. Issues around recruitment and retention have also been included in addition to some further information around the setting up of a Partnership Board with Liverpool University Hospitals NHS FT (LUH), as related topics.

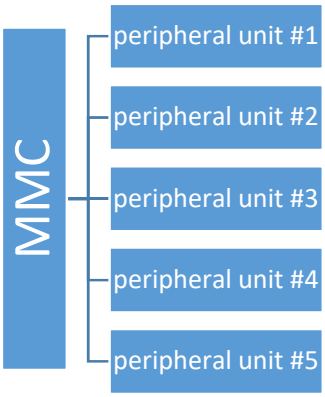
Networked Maternal Medicine Services

NHSE/I have committed to ensure that all women in England have access to a level of expert clinical care before, during and after pregnancy that is commensurate with their clinical condition, if a significant medical problem is encountered. The national plan is to achieve this by establishing new Networked Maternal Medicine Services (NMMS), each with a Maternal Medicine Centre (MMC) at its heart.

Each MMC will be staffed by an experienced multidisciplinary team including an obstetrician with sub-specialty training in maternal medicine (or equivalent) and an obstetric physician (or equivalent) along with input from all relevant other medical specialists and support from specialist midwives. For the delivery of maternal medicine services within a given footprint, the MMCs will:

- Provide a leadership role
- Liaise with the other providers of maternity care in its footprint
- Agree pathways of care and patterns of referral
- Ensure that women are cared for by clinicians will an appropriate level of expertise.

Peripheral units will provide much of the maternal medical care required for women of low to medium complexity. The referral of some high risk or complex cases from across any given NMMS footprint into its MMC for the delivery of care is, however, inevitable.



To become an MMC, a trust must comply with a nationally determined service specification with its range of associated standards. An assessment against that service specification has been carried out by the Clinical Director for Maternity at LWH and this has been included as an Appendix to this paper. The trust can demonstrate compliance against most of required elements but it is not co-located with other adult acute specialties, so full compliance has not been achieved.

In view of these constraints, earlier this year, the trust submitted a joint bid with other partners across the North West, outlining a proposal to develop an NMMS which will cover three LMS areas; Greater Manchester and Eastern Cheshire, Cheshire and Mersey and Lancashire and South Cumbria. In this proposal:

- An MMC will be established at Saint Mary's Hospital at Manchester University NHS Foundation Trust (MFT). This centre can comply in full with the service specification as its women's services are co-located with other adult acute services
- Two sub-centres will be developed including one at LWH, allowing most but not all women to be treated closer to home. Referral from Cheshire and Merseyside into MFT will be required for some women with severe medical problems: around ten per year will receive most of their care at MFT and a higher number will attend MFT for one or more outpatient reviews.

Establishing LWH as a sub-centre for maternal medicine will require the appointment of an obstetric physician in Liverpool. The Clinical Director for Maternity is presently working with partners at LUH to identify an appropriate clinician for this role. He is also writing to colleagues across Cheshire and Merseyside in order to formalise existing referral pathways for patients.

Gynaecological Oncology

The gynaecological oncology service at the LWH is under significant pressure at the present time, with a high level of activity required yet a low number of consultants with subspecialist skills available to deliver the clinical work. Of the 6.0 WTE budgeted subspecialist consultant posts, the trust currently has 4.0 WTE in post and of these, one is currently on long term sick leave and one will be leaving the trust for Manchester within the next month. In recent years, recruitment to these posts has proven to be extremely challenging. This has in part been due to the fact that there are more posts available across the UK than there are subspecialist trainees to fill them. LWH does not present itself as an attractive prospect to candidates, however, because of its isolated position on Crown Street. Modern

gynaecological oncologists expect to work in a facility with full access to multidisciplinary care, access to robotic surgery and access to an ITU since these services are necessary for the best clinical outcomes to be achieved.

Partly as a consequence of senior staffing shortages, the trust is not currently meeting its 31 and 62 day referral to treatment cancer targets and activity is underperforming against plan. In mitigation, the job plans of the trust's remaining gynaecological oncologists have been re-written with all benign gynaecological commitments now removed. In addition, a (non-subspecialist) consultant gynaecologist with an interest in oncology has been appointed, who is providing clinical support and who is helping to co-ordinate clinical activity. The drive to recruit subspecialists, however, continues.

In order to make these senior posts more attractive to potential candidates and simultaneously to improve our clinical services, an increased level of access to operating lists at LUH has been achieved. These consist of one all day list at Aintree University Hospital each week and one extended (10 hour) all day list at The Royal Hospital each fortnight, each with colorectal support and access to the respective ITUs. Discussions about the future provision of surgery at LUH are on-going but the present aim is to achieve:

- One all day list for open surgery at either The Royal or Aintree each week
- One all day list for robotic surgery at The Royal each week
- Each with access to critical care and ward accommodation for LWH patients
- Protected multidisciplinary team working from all relevant specialties
- Formal pathways to be established around access to specialist pre-operative testing
- Establishment of gynaecological nursing support on the LUH sites for LWH patients
- Improved access to imaging and diagnostic services
- Improved access to therapies and support services

These matters are being pursued individually by the MD at LWH and DMD at LUH but they will also be formalised as part of the Partnership Board's workstream once it has been established, described in more detail below.

Repatriating Gynaecological Oncology

The option of repatriating the gynae oncology workload has been considered. There are three options.

The first option would be to discontinue the service at LWH and recommission it at either Preston or Manchester, both of which are presently active in the field. This option has been excluded to date in part because of geographical constraints - the patients using the service live across the Cheshire and Mersey footprint but most live in Liverpool. Equally pertinent is the fact that it is highly unlikely that either Preston or Manchester would have the physical or operational capacity to deal with the increased volume of work that would accompany the change. The option remains under consideration but is presently seen as impractical.

The second option would be to discontinue the service at LWH and recommission it at the newly formed Liverpool University Hospitals trust, either at the Royal or the Aintree site. In this scenario, all relevant staff would transfer to LUH and out-patient, ward and theatre activity would follow suit. The work would be commissioned with LUH and LWH would simply refer patients with newly diagnosed gynaecological cancers into that service. This option has been excluded to date because an on-site presence would be required 24/7 from suitably skilled O&G trainees for the safe care of the patients. This would not be possible at present because a 20% rota gap rate is the norm for O&G trainees across Cheshire and Mersey. This would be negatively impacted by the introduction of an additional clinically active site. The subspecialist Consultant Gynae Oncologists do not believe that either ANPs or trainees from a non-O&G

specialty would have the knowledge and expertise required to provide safe care to the gynae cancer in-patient population, in place of cover from O&G trainees, on either the Royal or Aintree sites.

In both of the above options, the loss of Consultant Gynaecological Oncologists from the LWH workforce would have a significant detrimental effect upon the rest of the service. Specifically, massive postpartum haemorrhage is a key risk in the obstetric services and life-saving surgical rescue in the most extreme cases is provided primarily by the gynae oncology team. Caesarean hysterectomy is performed around six times per year at LWH in response to rapid, massive blood loss and the deterioration in on-site surgical expertise accompanying the repatriation of gynae oncology services would clearly increase the risk of exsanguination in these patients.

The third option is for LWH to retain its gynaecological oncology services but to perform an increasing volume of work at neighbouring adult acute sites as describe above, both for women with advanced disease and for women with multiple medical or surgical co-morbidities. Of note, this third option could have a positive impact upon recruitment and retention although this remains to be tested. None of the above options provides the same impact against safety as the relocation of LWH in its entirety onto an adult acute site.

The Age Profile of Consultant Medical Staff

Doctors pursuing a career as a specialist in the UK must follow nationally recognised training pathways to gain relevant clinical experience and to obtain their advanced professional qualifications. These pathways have evolved over the years. The Calman reforms in the 1990s and Modernising Medical Careers in 2005, for example, funneled doctors into their chosen specialty at an early stage in their careers while the European Working Time Directive in 1998 reduced the year-on-year volume of clinical work that doctors were exposed to while working towards consultant status. These changes may have improved consultants' specialised knowledge and skills but they have also made them more reliant upon cross-specialty working when dealing with patients with multiple medical or surgical co-morbidities. Put simply, consultants who were born before 1970 could be described as being 'multi-skilled' whereas consultants who were born in 1970 or later could be described as being 'hyper-specialised.'

In obstetric, gynaecological and anaesthetic practice, an increasing number of women with significant medical and surgical co-morbidities are now presenting for care who would not previously have done so. In a medical environment populated by hyper-specialised rather than multi-skilled consultants, patient care must therefore be delivered by a range of specalists in a co-ordinated manner, yet this cannot be provided on LWH's Crown Street site. This

In 2018, 24/47 consultants in the trust's three acute adult specialties (just over 50%) could have been described as multi-skilled rather than hyper-specialised. In a simplistic model of recruitment and retention, if we accept that one hyper-specialised Consultant will be recruited each time a multi-skilled Consultant retires in coming years, then:

- By 2023 around 40% of our consultants will be multi-skilled
- By 2028 around 20% of our consultants will be multi-skilled
- By 2033 none of our consultants will be multi-skilled.

The data show that in the absence of relocation onto an adult acute site, the shift towards a hyper-specialised consultant workforce will add to the clinical risk associated with the trust's physical isolation in an incremental manner in coming years.

In the absence of relocation, a partial solution to the conundrum of a changing skill set amongst the trust's consultant workforce would be to increase the opportunities for the trust's clinical activities to take place in a multidisciplinary environment:

(a) Switching work that we presently do at Crown Street onto an adult acute site
(b) Bringing specialists from other disciplines onto the Crown Street site.

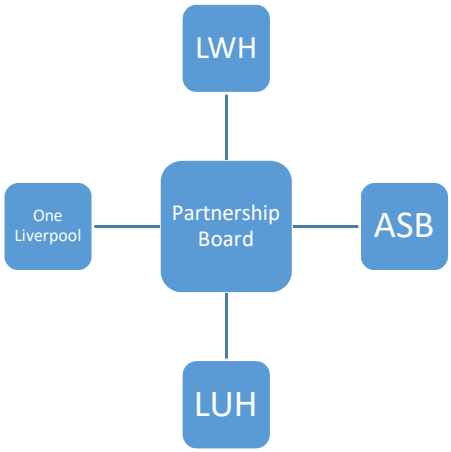
The CEOs of LWH and LUH have agreed to form a Partnership Board in order to address the trust's accumulating clinicial risk, including the element of risk posed by its changing consultant profile. Details about the proposed Partnership Board model have been provided below, with elements of (a) and (b) above included. Similarly germane, the trust's ability to recruit new consultants and to retain its present consultants has also been considered later in this paper.

Partnership Board

Following discussions between the respective CEOs of LWH and LUH, an MoU has been created for the formation of a Partnership Board between the two trusts. This group will be accountable to the respective Boards of Directors via the executive bodies and will have operational, medical and nursing/midwifery representation. It will further develop and formalise the 'virtual bridge' linking the two organisations with respect to the provision of clinical care. In addition to details given above around the provision of gynaecological oncology, the Partnership Board will examine the following:

- Partnership working for HDU provision at LWH which may include joint nursing and anaesthetic appointments, rotation across sites and support at LWH from LUH intensivists
- Consideration of the pattern of critical care outreach services that could feasibly be provided on the LWH site
- Formalisation of the working arrangements that allow for the provision of urgently needed specialist care from non-women's specialists on the LWH site
- Formalisation of the working arrangements that allow for the provision of urgently needed care from women's specialists on the LUH sites
- Review of the present pattern of delivery of maternal medicine services in the light of national drivers for change
- Establishment of a gynaecological nursing and midwifery presence on the LUH sites
- Formalisation of pathways for access to imaging and diagnostics on a seven day basis, with consideration of providing CT and extending other imaging facilities at the LWH site; including image generation and timely reporting
- Partnership working to provide staffing for a proposed new blood bank and extended lab facilities at LWH with 24/7 delivery of urgent services
- Formalisation of pathways surrounding access to seven day service requirements with respect to therapies, dietetics, pain management and tissue viability services

- Consideration of the potential for the use of the LWH site for LUH clinical activity where clinically appropriate, if this is needed to enable gynaecological activity on the LWH to be moved onto LUH sites
- Exploration of the use of digital technologies for the sharing of clinical information across sites to advance patient safety
- Formalisation of the process of safe repatriation of patients from LUH to LWH sites, taking into account the available services and facilities available at the LWH site
- Provision of oversight wrt the transfer of sick patients from LWH to LUH, reducing delayed transfer and minimising the risks associated with the transfer itself.



LWH has also suggested that NHSE/I and Liverpool CCG join that Partnership Board, which would then also report into (a) the One Liverpool place based care leadership group and (2) the Acute Sustainability Board for C&M. This would provide all parts of the system with continued sight until such time as the trust's clinical problems have been fully resolved.

Recruitment and Retention

The Trust is finding it difficult to recruit and retain consultants with the skills to maintain and develop its adult services. The problem has been highlighted above with respect to gynaecological oncologists but there have also been difficulties recruiting consultant anaesthetists and consultant gynaecologists with advanced skills in complex benign laparoscopic surgery. In future, obstetricians trained in maternal medicine may also prefer to work elsewhere as LWH is unable to meet the essential MMC criteria. This will have a negative impact upon the trust's prestige.

In principle, there are two ways in which the trust can maximise its potential for recruitment and retention and these are now being considered as a separate workstream by the Director of Workforce and Communication's team:

Optimise the professional offer

- Increased access to facilities off site (eg) multidisciplinary teams, robotic surgery
- Improved facilities on-site (eg) imaging, blood bank, digital
- Bespoke job plans to prioritise each consultant's professional preferences
- Attractive terms for study leave
- Overseas recruitment
- Promote the LWH brand.

Optimise the personal offer

- Part time working and job shares
- Annualised working hours
- Off site delivery of non clinical duties
- Leeway in holiday provision
- Attractive remuneration with respect to recruitment
- Attractive remuneration with respect to retention.

The establishment of a Partnership Board with LUH and the forging of closer working relationships may help with some of the 'professional offer' issues as it will provide LWH clinicians with access to a greater range of facilities and multidisciplinary expertise. Similarly, an expansion has been seen in the number of joint consultant anaesthetist posts with LUH and this is likely to continue but the services provided by LWH are otherwise highly specialised and the same opportunity is unlikely to be found in the trust's other clinical services. Without relocation, the recruitment and retention of consultants is likely to be problematic for the foreseeable future.

Conclusions

This report provides the Board of Directors with an update on progress against some of the key issues raised at the LWH Clinicial Summit of June 2019. The Board is asked to note its contents and to provide support for:

- The establishment of LWH as an MMC subcentre
- The further development of partnership working with LUH
- The principles behind a review of recruitment and retention for senior medical staff.

STANDARDS							2019 REVIEW: CURRENT CONFIGURATION				2019 REVIEW: IF CO-LOCATED WITH ROYAL SITE			
Ref	Classification	Service area	Specification	Standard	Source	Standing of Recommendation	Achieved	Non-Compliance Priority Level	Action Required/ Comments	Barrier to Achieving	Achieved	Non-Compliance Priority Level	Action Required/ Comments	Barrier to Achieving
NMMS01	Org of Services	NMMS	Co-dependency	Co-located with: • Obstetrics	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS02	Org of Services	NMMS	Co-dependency	Co-located with: • Gynaecology	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS03	Org of Services	NMMS	Co-dependency	Co-located with: • Neonatal intensive care: level 3	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS04	Org of Services	NMMS	Co-dependency	Co-located with: • Adult intensive care: Level 3, capable of multi-organ failure support.	NMMS Service Specification	NHSE/I Service Spec	No	HIGH	Not acheivable without co-location	Co-location	Yes			
NMMS05	Org of Services	NMMS	Co-dependency	Co-located with: • High Dependency beds: Level 2, staffed by medical and nursing teams experienced in managing pregnant women.	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS06	Org of Services	NMMS	Co-dependency	Co-located with: • Obstetric anaesthesia	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS07	Org of Services	NMMS	Co-dependency	Co-located with: • General surgery	NMMS Service Specification	NHSE/I Service Spec	No	HIGH	Not acheivable without co-location	Co-location	Yes			
NMMS08	Org of Services	NMMS	Co-dependency	Co-located with: • Acute Medicine	NMMS Service Specification	NHSE/I Service Spec	No	HIGH	Not acheivable without co-location	Co-location	Yes			
NMMS09	Org of Services	NMMS	Co-dependency	Co-located with: • Acute stroke services	NMMS Service Specification	NHSE/I Service Spec	No	MEDIUM	Not acheivable without co-location	Co-location	Yes			
NMMS10	Org of Services	NMMS	Co-dependency	Co-located with: • Cardiology General adult cardiology services, including acute cardiac care unit.	NMMS Service Specification	NHSE/I Service Spec	No	HIGH	Not acheivable without co-location	Co-location	Yes			
NMMS11	Org of Services	NMMS	Co-dependency	Co-located with: • Haematology and appropriate support services including blood transfusion and coagulation support	NMMS Service Specification	NHSE/I Service Spec	No	HIGH	Not acheivable without co-location	Co-location	Yes			
NMMS12	Org of Services	NMMS	Co-dependency	Co-located with: • Radiology with imaging	NMMS Service Specification	NHSE/I Service Spec	No	MEDIUM	Not acheivable without co-location	Co-location	Yes			
NMMS13	Workforce	NMMS	Co-dependency	Consultant able to provide emergency bedside care within 60 minutes: • Obstetrics	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS14	Workforce	NMMS	Co-dependency	Consultant able to provide emergency bedside care within 60 minutes: • Gynaecology	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS15	Workforce	NMMS	Co-dependency	Consultant able to provide emergency bedside care within 60 minutes: • Neonatal intensive care: level 3	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS16	Workforce	NMMS	Co-dependency	Consultant able to provide emergency bedside care within 60 minutes: • Adult intensive care: Level 3	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS17	Workforce	NMMS	Co-dependency	Consultant able to provide emergency bedside care within 60 minutes: • High Dependency beds: Level 2	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS18	Workforce	NMMS	Co-dependency	Consultant able to provide emergency bedside care within 60 minutes: • Obstetric anaesthesia	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS19	Workforce	NMMS	Co-dependency	Consultant able to provide emergency bedside care within 60 minutes: • General surgery	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS20	Workforce	NMMS	Co-dependency	Consultant able to provide emergency bedside care within 60 minutes: • Acute Medicine	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS21	Workforce	NMMS	Co-dependency	Consultant able to provide emergency bedside care within 60 minutes: • Acute stroke services	NMMS Service Specification	NHSE/I Service Spec	No	MEDIUM	In this scenario we would transfer out to LUHFT - confirm location of stroke servcies following merger clinical re-organisation	Co-location	Yes			
NMMS22	Workforce	NMMS	Co-dependency	Consultant able to provide emergency bedside care within 60 minutes: • Cardiology General adult cardiology services, including acute cardiac care unit.	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS23	Workforce	NMMS	Co-dependency	Consultant able to provide emergency bedside care within 60 minutes: • Haematology	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS24	Workforce	NMMS	Co-dependency	Consultant able to provide emergency bedside care within 60 minutes: • Radiology	NMMS Service Specification	NHSE/I Service Spec	No	MEDIUM	Patient would need to be transferred to imaging facilities. Exploring options for CT at LWH.	Co-location	Yes			
NMMS25	Org of Services	NMMS	Co-dependency	Specialty available to consult with a clinical assessment or telephone advice as appropriate within 12 hours: • Diabetes and Endocrinology	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS26	Org of Services	NMMS	Co-dependency	Specialty available to consult with a clinical assessment or telephone advice as appropriate within 12 hours: • Nephrology / Renal replacement therapy	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS27	Org of Services	NMMS	Co-dependency	Specialty available to consult with a clinical assessment or telephone advice as appropriate within 12 hours: • Respiratory	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS28	Org of Services	NMMS	Co-dependency	Specialty available to consult with a clinical assessment or telephone advice as appropriate within 12 hours: • Rheumatology	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS29	Org of Services	NMMS	Co-dependency	Specialty available to consult with a clinical assessment or telephone advice as appropriate within 12 hours: • Gastroenterology	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS30	Org of Services	NMMS	Co-dependency	Specialty available to consult with a clinical assessment or telephone advice as appropriate within 12 hours: • Neurology	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS31	Org of Services	NMMS	Co-dependency	Specialty available to consult with a clinical assessment or telephone advice as appropriate within 12 hours: • Vascular surgery	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS32	Org of Services	NMMS	Co-dependency	Specialty available to consult with a clinical assessment or telephone advice as appropriate within 12 hours: • Urology	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS33	Org of Services	NMMS	Co-dependency	Specialty available to consult with a clinical assessment or telephone advice as appropriate within 12 hours: • ENT	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			

Liverpool Women's Hospital - Service Standards for Networked Maternal Medicine Services

STANDARDS							2019 REVIEW: CURRENT CONFIGURATION				2019 REVIEW: IF CO-LOCATED WITH ROYAL SITE			
Ref	Classification	Service area	Specification	Standard	Source	Standing of Recommendation	Achieved	Non-Compliance Priority Level	Action Required/ Comments	Barrier to Achieving	Achieved	Non-Compliance Priority Level	Action Required/ Comments	Barrier to Achieving
NMMS34	Org of Services	NMMS	Co-dependency	Specialty available to consult with a clinical assessment or telephone advice as appropriate within 12 hours: • Oncology	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS35	Org of Services	NMMS	Co-dependency	Specialty available to consult with a clinical assessment or telephone advice as appropriate within 12 hours: • Dermatology	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS36	Org of Services	NMMS	Co-dependency	Specialty available to consult with a clinical assessment or telephone advice as appropriate within 12 hours: • TOP	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS37	Org of Services	NMMS	Co-dependency	Specialty available to consult with a clinical assessment or telephone advice as appropriate within 12 hours: • Fetal medicine	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS38	Workforce	NMMS	Workforce	Appointment of at least 1 obstetric physician (1.0WTE)	NMMS Service Specification	NHSE/I Service Spec	No	HIGH	Plan to liaise with LUHFT acute MD with regards appointing obstetric physician. Diabetes, renal & hypertension would represent 70% of activity. Haematology is more complex - require input from SME, same for inflammatory bowel, rheum, neuro, to be co-ordinated by obstetric physician as part of MDT work. Cardiac clinician already identified. Would look to work with LUHFT to develop trainee for future posts	Workforce	No	HIGH	Plan to liaise with LUHFT acute MD with regards appointing obstetric physician. Diabetes, renal & hypertension would represent 70% of activity. Haematology is more complex - require input from SME, same for inflammatory bowel, rheum, neuro, to be co-ordinated by obstetric physician as part of MDT work. Cardiac clinician already identified. Would look to work with LUHFT to develop trainee for future posts	Workforce
NMMS39	Workforce	NMMS	Workforce	Apppointment of at least one specialist obstetrician (0.5WTE) with expertise in medical problems in pregnancy (sub-specialist in Maternal Fetal Medicine or	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS40	Workforce	NMMS	Workforce	Appointment of at least 1 band 7 midwife (1.0WTE)	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS41	Workforce	NMMS	Workforce	Arrangements for appropriate cover within the centre out of hours	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS42	Workforce	NMMS	Workforce	Provision of maternal medicine advice availability 24/7	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS43	Workforce	NMMS	MDT Working	Dedicated specialist multidisciplinary team (MDT) that meets weekly to consider case management and to review outcomes of pregnancies cared for in the service. The MDT should include: • a lead specialist obstetrician or obstetricians with evidenced clinical expertise and appropriate competency in maternal medicine. • a lead obstetric physician with evidenced clinical expertise and appropriate competency in obstetric medicine. • specialist/advanced clinical practice (band 7) midwife or midwives with expertise in antenatal, intrapartum and post-partum management of women with medical problems.	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS44	Workforce	NMMS	Workforce	Operational resilience plan in place, including succession planning	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS45	Training and Revalidation	NMMS	Eductation and Training	Ability to deliver CPD for all staff involved in delivering maternal medicine care. The competency-based programme should focus on the acquisition of knowledge and skills such as clinical examination, assessment, diagnostic reasoning, treatment, facilitating and evaluating care, evidence-based practice and communication. Skills in teaching, research, audit, guideline development and management will also be part of the programme.	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS46	Training and Revalidation	NMMS	Eductation and Training	Ability to deliver standardised training and competency-based education programmes across the NMMS footprint to identify key red flags and indications for referral.	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS47	Org of Services	NMMS	Audit	Ability to demonstrate a robust policy for collaboration with other MMCs and with NHS commissioners for audit, including formal inter-unit peer review at least every five years.	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS48	Org of Services	NMMS	Operational Management	Ability to provide a dedicated management group for the internal management and coordination of service delivery. The group should comprise the different departments and disciplines delivering the service.	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS49	Clinical Practice	NMMS	Women-centred care	MMCs should demonstrate that arrangements are in place that allow women to participate in decision-making at every stage in their care. MMCs should contribute to the personalised care plan for every woman receiving care or advice.	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			

STANDARDS							2019 REVIEW: CURRENT CONFIGURATION				2019 REVIEW: IF CO-LOCATED WITH ROYAL SITE			
Ref	Classification	Service area	Specification	Standard	Source	Standing of Recommendation	Achieved	Non-Compliance Priority Level	Action Required/ Comments	Barrier to Achieving	Achieved	Non-Compliance Priority Level	Action Required/ Comments	Barrier to Achieving
NMMS50	Clinical Practice	NMMS	Women-centred care	Women should be given a detailed written care plan forming a patient care record in plain language identifying follow up arrangements. The plan should be copied (with consent) to all involved clinicians and the woman's GP.	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS52	Workforce	NMMS	Workforce	Have a sufficient case load to justify a regular clinic staffed jointly by a specialist consultant obstetrician and physician, who provide a defined service to which referrals can be made, and advice sought	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS53	Clinical Practice	NMMS	Women-centred care	• Demonstrate that care is centred around women, with multi-disciplinary joint consultations and appropriate support from specialist nurses, midwives and anaesthetists.	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS54	Org of Services	NMMS	Co-dependency	• Have access to other medical, surgical, fetal medicine, clinical genetics and level 3 Neonatal Intensive Care services where needed	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS55	Org of Services	NMMS	Pre-Pregnancy Care	• Have a pre-pregnancy counselling service to generate a personalised care plan that covers ante-natal, intra-partum and postnatal periods. This will include clear instructions for shared care with secondary services where appropriate, including escalation and transfer protocols.	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS56	Clinical Practice	NMMS	Intrapartum Care	• Have clear guidelines for planned and emergency delivery	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS57	Org of Services	NMMS	Co-dependency	• Be part of a network with distinct pathways to facilitate timely and easy access to specialist advice	NMMS Service Specification	NHSE/I Service Spec	Yes		Formalise care pathways with CDs at S&O, Whiston, Warrington, Chester, Crewe, Arrowe Park		Yes			
NMMS58	Workforce	NMMS	Workforce	• Have the necessary resources and multidisciplinary expertise to support, if needed, all stages of the care pathway within an appropriate timescale including termination of pregnancy where requested as well as labour and delivery	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS59	Clinical Practice	NMMS	Postnatal Care	• For Postnatal care – provide a written discharge summary and include detailed plans for follow up, return to physician care and contraception, with a plan for future pregnancy if appropriate	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS60	Org of Services	NMMS	Audit	• Take part in regular robust audit which should also include measures of user experience.	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS61	Org of Services	NMMS	IM&T	• Record care data for all women seen by the service in an electronic patient record (maternity information system including diagnosis codes, which should be submitted monthly as part of the Trusts' Maternity Services Data Set (MSDS) submission.	NMMS Service Specification	NHSE/I Service Spec	Yes				Yes			
NMMS62	Org of Services	NMMS	Antenatal Care	Statement 1. Pregnant women are supported to access antenatal care, ideally by 10 weeks 0 days.	Antenatal Care Quality Standards 2012	NICE	Yes				Yes			
NMMS63	Clinical Practice	NMMS	Antenatal Care	Statement 2. Pregnant women are cared for by a named midwife throughout their pregnancy.	Antenatal Care Quality Standards 2012	NICE	Yes				Yes			
NMMS64	Clinical Practice	NMMS	Antenatal Care	Statement 3. Pregnant women have a complete record of the minimum set of antenatal test results in their hand-held maternity notes.	Antenatal Care Quality Standards 2012	NICE	Yes				Yes			
NMMS65	Clinical Practice	NMMS	Antenatal Care	Statement 4. Pregnant women with a body mass index of 30 kg/m2 or more at the booking appointment are offered personalised advice from an appropriately trained person on healthy eating and physical activity.	Antenatal Care Quality Standards 2012	NICE	Yes				Yes			
NMMS66	Clinical Practice	NMMS	Antenatal Care	Statement 5. Pregnant women who smoke are referred to an evidence-based stop smoking service at the booking appointment.	Antenatal Care Quality Standards 2012	NICE	Yes				Yes			
NMMS67	Clinical Practice	NMMS	Antenatal Care	Statement 6. Pregnant women are offered testing for gestational diabetes if they are identified as at risk of gestational diabetes at the booking appointment.	Antenatal Care Quality Standards 2012	NICE	Yes				Yes			
NMMS68	Clinical Practice	NMMS	Antenatal Care	Statement 8. Pregnant women at intermediate risk of venous thromboembolism at the booking appointment have specialist advice provided about their care.	Antenatal Care Quality Standards 2012	NICE	Yes				Yes			
NMMS69	Clinical Practice	NMMS	Antenatal Care	Statement 9. Pregnant women at high risk of venous thromboembolism at the booking appointment are referred to a specialist service.	Antenatal Care Quality Standards 2012	NICE	Yes				Yes			
NMMS70	Clinical Practice	NMMS	Antenatal Care	Statement 10. Pregnant women are offered fetal anomaly screening in accordance with current UK National Screening Committee programmes.	Antenatal Care Quality Standards 2012	NICE	Yes				Yes			
NMMS71	Clinical Practice	NMMS	Antenatal Care	Statement 11. Pregnant women with an uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) are offered external cephalic	Antenatal Care Quality Standards 2012	NICE	Yes				Yes			
NMMS72	Clinical Practice	NMMS	Antenatal Care	Statement 12. Nulliparous pregnant women are offered a vaginal examination for membrane sweeping at their 40- and 41-week antenatal appointments, and parous pregnant women are offered this at their 41-week appointment.	Antenatal Care Quality Standards 2012	NICE	Yes				Yes			
NMMS73	Clinical Practice	NMMS	AN & PN Mental Health Care	Statement 1 Women of childbearing potential are not prescribed valproate to treat a mental health problem.	Antenatal and postnatal mental health Care Quality Stds, 2016	NICE	Yes		Close liaison between epilepsy service at Walton Centre, Dr C Burness & Dr J Winterbottom, with Kieran Jilani as specialist for pre pregnancy assessment and management		Yes			

STANDARDS							2019 REVIEW: CURRENT CONFIGURATION				2019 REVIEW: IF CO-LOCATED WITH ROYAL SITE			
Ref	Classification	Service area	Specification	Standard	Source	Standing of Recommendation	Achieved	Non-Compliance Priority Level	Action Required/ Comments	Barrier to Achieving	Achieved	Non-Compliance Priority Level	Action Required/ Comments	Barrier to Achieving
NMMS74	Clinical Practice	NMMS	AN & PN Mental Health Care	Statement 2 Women of childbearing potential with a severe mental health problem are given information at their annual review about how their mental health problem and its treatment might affect them or their baby if they become pregnant.	Antenatal and postnatal mental health Care Quality Stds, 2016	NICE	Yes				Yes			
NMMS75	Clinical Practice	NMMS	AN & PN Mental Health Care	Statement 3 Pregnant women with a previous severe mental health problem or any current mental health problem are given information at their booking appointment about how their mental health problem and its treatment might affect them or their	Antenatal and postnatal mental health Care Quality Stds, 2016	NICE	Yes				Yes			
NMMS76	Clinical Practice	NMMS	AN & PN Mental Health Care	Statement 4 Women are asked about their emotional wellbeing at each routine antenatal and postnatal contact.	Antenatal and postnatal mental health Care Quality Stds, 2016	NICE	Yes				Yes			
NMMS77	Clinical Practice	NMMS	AN & PN Mental Health Care	Statement 5 Women with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive mental health assessment.	Antenatal and postnatal mental health Care Quality Stds, 2016	NICE	Yes				Yes			
NMMS78	Clinical Practice	NMMS	AN & PN Mental Health Care	Statement 6 Women referred for psychological interventions in pregnancy or the postnatal period start treatment within 6 weeks of referral.	Antenatal and postnatal mental health Care Quality Stds, 2016	NICE	Yes				Yes			
NMMS79	Clinical Practice	NMMS	AN & PN Mental Health Care	Statement 7 (developmental) Specialist multidisciplinary perinatal community services and inpatient psychiatric mother and baby units are available to support women with a mental health problem in pregnancy or the postnatal period.	Antenatal and postnatal mental health Care Quality Stds, 2016	NICE	Yes				Yes			
NMMS80	Clinical Practice	NMMS	Antenatal Care	Statement 1. Pregnant women who have had 1 or more previous caesarean sections have a documented discussion of the option to plan a vaginal birth.	Caesarean section Quality Statement, 2013	NICE	Yes				Yes			
NMMS81	Clinical Practice	NMMS	Antenatal Care	Statement 2. Pregnant women who request a caesarean section (when there is no clinical indication) have a documented discussion with members of the maternity team about the overall risks and benefits of a caesarean section compared with vaginal birth.	Caesarean section Quality Statement, 2013	NICE	Yes				Yes			
NMMS82	Clinical Practice	NMMS	Antenatal Care	Statement 3. Pregnant women who request a caesarean section because of anxiety about childbirth are referred to a healthcare professional with expertise in perinatal mental health support.	Caesarean section Quality Statement, 2013	NICE	Yes				Yes			
NMMS83		NMMS	Antenatal Care	Statement 4. Pregnant women who may require a planned caesarean section have consultant involvement in decision-making.	Caesarean section Quality Statement, 2013	NICE	Yes				Yes			
NMMS84		NMMS	Intrapartum Care	Statement 5. Pregnant women having a planned caesarean section have the procedure carried out at or after 39 weeks 0 days, unless an earlier delivery is necessary because of maternal or fetal indications.	Caesarean section Quality Statement, 2013	NICE	Yes				Yes			
NMMS85		NMMS	Intrapartum Care	Statement 6. Women being considered for an unplanned caesarean section have a consultant obstetrician involved in the decision.	Caesarean section Quality Statement, 2013	NICE	Yes				Yes			
NMMS86		NMMS	Intrapartum Care	Statement 7. Women in labour for whom a caesarean section is being considered for suspected fetal compromise are offered fetal blood sampling to inform decision-making.	Caesarean section Quality Statement, 2013	NICE	Yes				Yes			
NMMS87		NMMS	Postnatal Care	Statement 8. Women who have had a caesarean section are offered a discussion and are given written information about the reasons for their caesarean section and birth options for future pregnancies.	Caesarean section Quality Statement, 2013	NICE	Yes				Yes			
NMMS88		NMMS	Postnatal Care	Statement 9. Women who have had a caesarean section are monitored for postoperative complications.	Caesarean section Quality Statement, 2013	NICE	Yes				Yes			
NMMS89		NMMS	Pre-Pregnancy Care	Statement 1. Women with diabetes planning a pregnancy are prescribed 5 mg/day folic acid from at least 3 months before conception.	Diabetes in pregnancy Quality Statement, 2013	NICE	Yes		Liverpool Diabetes Partnership works across secondary and primary services		Yes			
NMMS90		NMMS	Antenatal Care	Statement 2. Women with pre-existing diabetes are seen by members of the joint diabetes and antenatal care team within 1 week of their pregnancy being confirmed.	Diabetes in pregnancy Quality Statement, 2013	NICE	Yes				Yes			
NMMS91		NMMS	Antenatal Care	Statement 3. Pregnant women with pre-existing diabetes have their HbA1c levels measured at their booking appointment.	Diabetes in pregnancy Quality Statement, 2013	NICE	Yes				Yes			
NMMS92		NMMS	Antenatal Care	Statement 4. Pregnant women with pre-existing diabetes are referred at their booking appointment for retinal assessment.	Diabetes in pregnancy Quality Statement, 2013	NICE	Yes				Yes			
NMMS93		NMMS	Antenatal Care	Statement 5. Women diagnosed with gestational diabetes are seen by members of the joint diabetes and antenatal care team within 1 week of diagnosis.	Diabetes in pregnancy Quality Statement, 2013	NICE	Yes				Yes			
NMMS94		NMMS	Antenatal Care	Statement 6. Pregnant women with diabetes are supported to self-monitor their blood glucose levels.	Diabetes in pregnancy Quality Statement, 2013	NICE	Yes				Yes			
NMMS95		NMMS	Postnatal Care	Statement 7. Women who have had gestational diabetes have an annual HbA1c test.	Diabetes in pregnancy Quality Statement, 2013	NICE	Yes		LWH Informs woman and primary health care of requirement		Yes			
NMMS96		NMMS	Pre-Pregnancy Care	Statement 1 Women of childbearing potential with treated hypertension are given information annually about safe antihypertensive treatment during pregnancy.	Hypertension in pregnancy Quality Statement, 2013	NICE	N/A		Primary care requirement		N/A		Primary care requirement	
NMMS97		NMMS	Antenatal Care	Statement 2 Pregnant women at increased risk of pre-eclampsia at the booking appointment are offered a prescription of 75–150 mg of aspirin[1] to take daily from 12 weeks until birth.	Hypertension in pregnancy Quality Statement, 2013	NICE	Yes				Yes			

STANDARDS							2019 REVIEW: CURRENT CONFIGURATION				2019 REVIEW: IF CO-LOCATED WITH ROYAL SITE			
Ref	Classification	Service area	Specification	Standard	Source	Standing of Recommendation	Achieved	Non-Compliance Priority Level	Action Required/ Comments	Barrier to Achieving	Achieved	Non-Compliance Priority Level	Action Required/ Comments	Barrier to Achieving
NMMS98		NMMS	Antenatal Care	Statement 3 Pregnant women taking antihypertensive medication have a blood pressure target of 135/85 mmHg or less.	Hypertension in pregnancy Quality Statement, 2013	NICE	Yes				Yes			
NMMS99		NMMS	Antenatal Care	Statement 4 Pregnant women with severe hypertension are admitted for a full assessment, carried out by a healthcare professional trained in managing hypertension in pregnancy.	Hypertension in pregnancy Quality Statement, 2013	NICE	Yes				Yes			
NMMS100		NMMS	Antenatal Care	Statement 5 Women with pre-eclampsia who have severe hypertension or are at a high risk of adverse events, or if there are any clinical concerns are admitted to hospital and monitored.	Hypertension in pregnancy Quality Statement, 2013	NICE	Yes				Yes			
NMMS101		NMMS	Antenatal Care	Statement 6 Women with pre-eclampsia have a senior obstetrician involved in any decisions about the timing of birth.	Hypertension in pregnancy Quality Statement, 2013	NICE	Yes				Yes			
NMMS102		NMMS	Postnatal Care	Statement 7 Women who have had hypertension in pregnancy have a plan for ongoing antihypertensive management included in their postnatal care plan, which is communicated to their GP when they are transferred to community care after the birth.	Hypertension in pregnancy Quality Statement, 2013	NICE	Yes				Yes			
NMMS103		NMMS	Postnatal Care	Statement 8 Women who have had gestational hypertension or pre-eclampsia discuss future pregnancy and lifetime cardiovascular risks during a medical review at their 6–8 week postnatal medical check.	Hypertension in pregnancy Quality Statement, 2013	NICE	Yes				Yes			
NMMS104		NMMS	Antenatal Care	Statement 1 Women with a multiple pregnancy have the chorionicity and amnionicity of their pregnancy determined using ultrasound and recorded between 11+2 weeks and 14+1 weeks.	Multiple pregnancy: twin and triplet pregnanciesy Quality Statement, 2013	NICE	Yes				Yes			
NMMS105		NMMS	Antenatal Care	Statement 2 Women with a multiple pregnancy have their fetuses labelled using ultrasound and recorded between 11+2 weeks and 14+1 weeks.	Multiple pregnancy: twin and triplet pregnanciesy Quality Statement, 2013	NICE	Yes				Yes			
NMMS106		NMMS	Antenatal Care	Statement 3 Women with a multiple pregnancy are cared for by a multidisciplinary core team.	Multiple pregnancy: twin and triplet pregnanciesy Quality Statement, 2013	NICE	Yes				Yes			
NMMS107		NMMS	Antenatal Care	Statement 4 Women with a multiple pregnancy have a care plan that specifies the timing of appointments with the multidisciplinary core team appropriate for the chorionicity and amnionicity of their pregnancy.	Multiple pregnancy: twin and triplet pregnanciesy Quality Statement, 2013	NICE	Yes				Yes			
NMMS108		NMMS	Antenatal Care	Statement 5 Women with a multiple pregnancy are monitored for fetal complications according to the chorionicity and amnionicity of their pregnancy.	Multiple pregnancy: twin and triplet pregnanciesy Quality Statement, 2013	NICE	Yes				Yes			
NMMS109		NMMS	Antenatal Care	Statement 6 Women with a higher-risk or complicated multiple pregnancy have a consultant from a tertiary level fetal medicine centre involved in their care.	Multiple pregnancy: twin and triplet pregnanciesy Quality Statement, 2013	NICE	Yes				Yes			
NMMS110		NMMS	Antenatal Care	Statement 7 Women with a multiple pregnancy have a discussion by 24 weeks with one or more members of the multidisciplinary core team about the risks, signs and symptoms of preterm labour and possible outcomes of preterm birth.	Multiple pregnancy: twin and triplet pregnanciesy Quality Statement, 2013	NICE	Yes				Yes			
NMMS111		NMMS	Antenatal Care	Statement 8 Women with a multiple pregnancy have a discussion by 28 weeks with one or more members of the multidisciplinary core team about the timing of birth and possible modes of delivery so that a birth plan can be agreed.	Multiple pregnancy: twin and triplet pregnanciesy Quality Statement, 2013	NICE	Yes				Yes			
NMMS112		NMMS	TOP	1. All women should be provided with information about the purpose and potential outcomes of antenatal screening tests to detect fetal abnormalities and should have an opportunity to discuss their options, before the test is performed (section 6).	Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales, 2010	RCOG	Yes				Yes			
NMMS113		NMMS	TOP	2. A robust management pathway must be in place to ensure that appropriate information and support are available. For most major fetal abnormalities, referral to a doctor with expertise in fetal medicine is recommended (section 6).	Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales, 2010	RCOG	Yes				Yes			
NMMS114		NMMS	TOP	3. All practitioners performing fetal anomaly ultrasound screening should be trained to impartinformationaboutabnormalfindingsto womenandahealthprofessionalshould be available to provide immediate support to the woman and her partner (section 6).	Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales, 2010	RCOG	Yes				Yes			
NMMS115		NMMS	TOP	4. Optimal care for women after a diagnosis of fetal abnormality relies on a multidisciplinary approach. Those involved should be clear about their own roles and should ensure thatthe womanis carefully guidedalong a plannedcare pathway by fully briefed and supportive staff (section 6).	Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales, 2010	RCOG	Yes				Yes			
NMMS116		NMMS	TOP	5. All staff involved in the care of a woman or couple facing a possible termination of pregnancy must adopt a non-directive, non-judgemental and supportive approach (section 6).	Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales, 2010	RCOG	Yes				Yes			
NMMS117		NMMS	TOP	6. It should not be assumed that, even in the presence of an obviously fatal fetal condition such as anencephaly, a woman will choose to have a termination. A decision to decline the offer of termination must be fully supported (section 6).	Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales, 2010	RCOG	Yes				Yes			

STANDARDS							2019 REVIEW: CURRENT CONFIGURATION				2019 REVIEW: IF CO-LOCATED WITH ROYAL SITE			
Ref	Classification	Service area	Specification	Standard	Source	Standing of Recommendation	Achieved	Non-Compliance Priority Level	Action Required/ Comments	Barrier to Achieving	Achieved	Non-Compliance Priority Level	Action Required/ Comments	Barrier to Achieving
NMMS118		NMMS	TOP	7. Live birth following termination of pregnancy before 21+6 weeks of gestation is very uncommon. Nevertheless, women and their partners should be counselled about this unlikely possibility and staff should be trained to deal with this eventuality (section	Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales, 2010	RCOG	Yes				Yes			
NMMS119		NMMS	TOP	8. Live birth becomes increasingly common after 22 weeks of gestation and, when a decision has been reached to terminate the pregnancy for a fetal abnormality after 21+6 weeks, feticide should be routinely offered. When the fetal abnormality is not compatible with survival, termination of pregnancy without prior feticide may be preferred by some women. In such cases, the delivery management should be discussed and planned with the parents and all health professionals involved and a written care plan agreed before the termination takes place (section 8).	Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales, 2010	RCOG	Yes				Yes			
NMMS120		NMMS	TOP	9. Where the fetal abnormality is not lethal and termination of pregnancy is being undertaken after 21+6 weeks of gestation, failure to perform feticide could result in live birth and survival, an outcome that contradicts the intention of the abortion. In such situations, the child should receive the neonatal support and intensive care that is in the child's best interests and its condition managed within published guidance for neonatal practice. A fetus born alive with abnormalities incompatible with life should be managed to maintain comfort and dignity during terminal care (section 8).	Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales, 2010	RCOG	Yes				Yes			
NMMS121		NMMS	TOP	10. After a termination for fetal abnormality, well-organised follow-up care is essential (section 6).	Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales, 2010	RCOG	Yes				Yes			
NMMS122		NMMS	TOP	11. The Working Party recognises the need for the National Health Service Fetal Anomaly Screening Programmes to be linked to databases that enable detection rates of specific congenital abnormalities to be monitored and the impact of the programmes to be evaluated. It is therefore recommended that these programmes are linked to systems which aim to provide continuous monitoring of the frequency, nature and outcomes of congenital anomalies in live or stillborn infants and fetuses in England, Scotland and Wales. An appropriately funded and centrally coordinated system of congenital anomaly ascertainment that covers all parts of the country is essential (section 4).	Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales, 2010	RCOG	Yes				Yes			
NMMS123		NMMS	TOP	12. Outcome data on children born with specific abnormalities are required to provide better information on natural history and prognosis. These data would enable a more accurate assignment of prognosis and better informed prenatal counselling in the future. The Working Party recommends that the envisaged 2-year data collection for preterm infants should be expanded to collect outcome data for infants with abnormalities (section 4).	Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales, 2010	RCOG	Yes				Yes			
NMMS124		NMMS	TOP	13. Abortion statistics for England and Wales for 2008 report that 124 terminations for fetal anomalies (Ground E) were performed of pregnancies over 24 weeks of gestation. As numbers in most categories of abnormality were fewer than ten, the nature of the abnormalities is not disclosed and trends or patterns in termination cannot be determined. We recommend that such information is published in the Department of Health Abortion Statistics on a 3- and 6-year cycle (section 4).	Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales, 2010	RCOG	n/a		DHSC requirement		n/a		DHSC requirement	

Liverpool Women's NHS Foundation Trust

Agenda Item	2019/171

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Learning from Incidents**
DATE OF MEETING:	Thursday, 07 November 2019
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Caron Lappin, Director of Nursing and Midwifery
AUTHOR(S):	Christopher Lube Head of Governance and Quality, Claire Fitzpatrick, Head of Midwifery, Melanie Pickering, Head of Nursing-Gynaecology and Jen Deeney, Head of Nursing and Operations-Neonatal
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE*** *- people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ ***RESPONSIVE –*** *the services meet people's needs.* ☒ ***WELL-LED -*** *the leadership, management and governance of the* ☐

	organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture. ***ALL DOMAINS*** ☐			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☒ **3.** NHS Compliance ☒		**4.** NHS Constitution ☐ **5.** Equality and Diversity ☒ ***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board members are requested to review the contents of the paper and gain assurance that learning from incidents is being achieved in the Trust.			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable		
	Date of meeting			

Executive Summary

The following paper has been developed for review at the board meeting following a request from the Trust Chairman. The aim of the paper is to provide assurance that lessons from incidents are being identified and then disseminated across the clinical area and the Trust where applicable.

Learning lessons from Serious Incidents and Incidents that are more general is an essential element of ensuring patient safety within our clinical services and supporting our staff in their own safety and development. If we do not learn the lessons identified, then incidents will reoccur, more patients will be harmed and the Trusts reputation will be at impacted upon, as well as possible increased financial impact, due to increased claims.

The Trust currently has a policy in place for the Management of Incidents and Serious Incidents, this policy was last reviewed and updated in the summer of 2018 and approved by the Safety Senate. The updated policy was developed from regional and national guidance and incorporates previous Trust Standard Operating Procedures. The aim of the review and amalgamation of documents was to create one cohesive document that all staff could easily access which covered all areas.

Report

The three Divisions of Family Health, Gynaecology and Clinical Support Services have provided examples of Serious Incidents and General Incidents to inform this report. Each of the Divisions has provided the incident, the lessons learnt and the outcome covering the period of October 2018 to October 2019 (appendix 1).

Number of incidents in the report:

Division	Number of incidents	
	Serious Incidents	General Incidents
Family Health	11	7
Gynaecology	4	7
Clinical Support Services	0	3 (key Themes)

Themes identified from Serious Incidents and general incidents with associated actions:

Themes	Associated Actions
Retained Object from Theatre Never Event	Review completed by Deputy Medical Director of all retained Objects in Theatre and this was presented at The Great Day All Relevant staff reminded of the processes to follow to prevent Never Event. Work ongoing with LocSSIPs Implementation group to embed processes in Theatre initially then outside of theatre. All ward staff provided with update information on the use for Yellow Bands.
Wrong Implant / Prosthesis (Coil) Never Event	To assist in the checking procedure in theatres a new section was added to Meditech, which requires the practitioner to add in which type of prosthesis is to be used.
Communication	Work is ongoing across the organisation in relation to improving communication. Central call centre created to improve telephone access to appointment for patients. Customer care training is planned for key administration and front line staff. Specific communication training called Sage and Thyme is being provided to key staff across the organisation to become in-house trainers; this will support staff in learning evidence-based communication skills to provide person-centred support. Written communication to patients is being reviewed to ensure it is effective.
Not Following Clinical Procedures or Processes	Depending on the incident, this may be an individual issue which is used for reflection and staff development or it may require the procedure / processes to be reviewed, updated or developed in in line with recent guidance or outcome of RCA. Following incident reviews, a number of clinical documents have been updated to ensure clarity of process or to add in a new process to ensure patient safety.
Poor documentation	Standards for documentation are clearly set out for nursing, midwifery and medical staff in professional guidance. The current situation with numerous electronic systems as well as papers records adds risk to the current system, which can lead to unintended mistakes or omissions in documentation.

	Following each review, where documentation has been identified as an issue, this is feedback to the individual staff or a review of process is completed. An annual documentation audit is completed across all clinical areas and the findings of this is feedback to divisions for them to action.
Lack of support services for acute conditions on site	This is a risk, which is highlighted more in incident reviews following the introduction of a specific question to be completed in the final SI report. This is a well-documented issue for the Trust, with the risk associated with sustainability currently being on the BAF.
Lack of embed Human Factors awareness	Human Factors training is provided in different areas of the Trust, but it is not fully embedded in association with MDT simulation training sessions for clinical staff. Further work is required to develop and embed Human Factors training for all clinical staff to develop situational awareness skills.

Conclusion

From the information provided in the report it can be seen that lessons from all Incidents are being identified and investigated and work to implement changes are either under way or in development. The management of incident policy is in place and with the involvement of not only key clinical staff, but also senior managers and executive directors in the RCA process. This allows a robust development of recommendations and actions to be completed supporting a strong ethos of learning lessons.

Work continues throughout the Divisions in the implementation of lessons learnt in all of the clinical areas when an incident has occurred, further work is required to disseminate those lessons across the organisation where appropriate. This is a key piece or work which is being developed looking at the communication to staff examples are; staff weekly digest, risk management web page, Trusts lessons learnt web page, 7 minute briefings, screen savers, in the Loop and Great Day sessions and the possible use of social media.

The effective dissemination of lessons learnt across any organisation is an ongoing challenge, which is constantly developing to meet the changing needs of staff and the organisation . The appointment of a new Risk and Patient Safety Manager, commencing Jan 2020, will provide further support and focus on disseminating and implementing lessons learnt in line with the new NHS Patient Safety Strategy (July 2019).

Recommendation

The Board members are requested to review the contents of the paper and gain assurance that learning from incidents is being achieved in the Trust.

Appendix 1

Division: Gynaecology and Hewitt Centre

Serious Incidents			
Location	**Incident overview**	**Learning identified**	**Outcome**
Gynaecology/ Theatres	Patient was discharged and on arriving home, the patient felt tissue coming from her vagina and on pulling it, found it was some sort of gauze. The patient contacted the ward and was advised to return to the ward or examination. On returning to the ward, the patient underwent a vaginal examination at which a piece of gauze was identified and removed.	• Update WHO Surgical Safety Checklist • Critically ill guideline to be reviewed. • Continued development of the Just and Fair Culture Programme • Discussion of review findings with the Consultants involved in the care of the patient.	• WHO Safety Checklist has been updated. • Lesson of the Week was developed and distributed within the Gynaecology Division on 28 September 2018 and Trust wide via Staff Track e-magazine on 4 October 2018. • Reflection of the incident by individual staff members.
Gynaecology Emergency Department	Bowel injury at the time of hysteroscopy, consultant asked for help from oncologist, performed laparoscopy and diagnosed bowel injury and then called on call surgeons from Royal Liverpool University Hospital who performed a laparotomy and small bowel resection and primary anastomosis.	• The uterine sound was passed to 7cm, 3cm greater than the size of the uterus thus likely perforating the uterus. • Emergency surgery carried out was timely, appropriately and primary anastomosis was achieved.	• Images from hysterocopies are now directly saved on the PACS system for approximately half of the stack systems in theatre. • The findings from the investigation were discussed at the Divisional Morbidity & Mortality Meeting on Friday 26 July 2019.
Gynaecology	Significant delay in surgery that resulted in the cysts growing in size and subsequently the patient suffered twisted and ruptured ovarian cysts. It is difficult to rule out the possibility that her endometriosis may have worsened in the interim resulting in more complex presentation. Had the surgery been performed earlier in 2018, the case may have been less	• Referral to Treat Training Package to be introduced for all Access Centre Staff. • Trust to purchase an end-to-end pathway management system. • Introduction of booking out facility for In Touch System.	• Project Plan for the implementation of Referral to Treat Training Package has been developed and is monitored by the Operational Manager. • End-to-end pathway system has been purchased; Patient Pathway Plus allows intelligent monitoring of patients and

	complex and/or the cyst (s) would have been smaller/not twisted or ruptured.	• A reliance on the system of paper outcome sheet, which is, used to record on meditech the decision following a clinical appointment.	pathways.
59701	Patient was admitted for a surgical termination of pregnancy and was consented for a surgical termination of pregnancy. Following her admission an additional procedure of insertion of a Copper Coil, TT380 Intrauterine Device was added to the consent form. This was recorded on the Patient Electronic Notes System (PENS). Following the surgical termination of pregnancy a Levosert Intrauterine System and not a TT390 Copper Coil was fitted.	• LocSSIPS Implementation Group to be developed. • The findings from this SI and other Never Events to be discussed in the Great Day. • Work with Information Technology Team to make completion of each step of the WHO checklist on PENS mandatory before moving to the next stage.	• LocSSIPS Implementation Group has been implemented and the first meeting took place on 14th February 2019. • Never Event Great Day took place on 14th March 2019. • PENS WHO Audit was transferred from Meditech to PENs on 9th September 2019. • WHO Champions have been identified.

General Incidents			
Location	**Incident overview**	**Learning identified**	**Outcome**
Hewitt Centre	Pelvic infection post a catheter test (embryo transfer catheter test)	• Whilst no issues were identified with the actual procedure the following points were noted: • We did not have a consent form for patients to complete prior to the procedure • There was no patient information leaflet / discussion re potential risks. • The procedure was not part of an SOP	• Consent form now in use • Patient Information leaflet in use • Embryo transfer SOP expanded to include performing catheter tests

Hewitt Centre	An oncology patient having an oocyte collection for fertility preservation experienced a respiratory complication during sedation. This required the resuscitation team to attend.	• The pre-operative assessment was ad hoc on the same day that ovarian stimulation was due to start and not via a specific anaesthetic clinic, therefore less time to collate all the relevant clinical information.	• Any HFC patient requiring an anaesthetic opinion must be referred to a C3 Clinic for a formal assessment.
Hewitt Centre	Repeated incident of mis-filing	• Meeting held with senior team leaders to identify an action plan	• Improve SOP's regarding Filing Procedures • Reassess induction process for new members of administration staff • Introduce safety huddle for the administration team • Administration agency staff in Knutsford (started Jan 2019) to help with shortage of staff members • Re-audit Misfiling Incidents
Hewitt Centre	Death of a patient (not related to treatment).	• Whilst we had identified that the patient had hypertension and acted accordingly we did not routinely check BP at the initial assessment of patients.	• BP check is now included in the medical history sheet for first consultations
Gynaecology Ward	The patient had undergone an elective vaginal vault biopsy in December. Consultant was keen to ensure heaomostatsis so applied heamostatic material (intended to be retained). Consultant also inserted a large vaginal pack, intended to be removed after 2 hours. The application of yellow band in theatre was recorded, but no evidence of removal. Patient was	• No swab had been retained. • The patient had passed clot and tumour tissue. • However, no documentation to record swab had been removed. • An AP with no countersignature from RN had completed this. • When a non-registered staff member records in the notes this must be supervised and signed off by a registered practitioner.	• Development of 7 minute briefing to share lessons learnt. • Briefing to be discussed at ward huddle and staff meetings. • Audit of documentation to be completed.

	seen in clinic in March 2019. She informed the medical team that she had passed a large item in February which could have been a swab.		
Gynaecology Ward	Immediate response to medication process problems, which were identified on the Gynaecology. Ward.	• Head of Nursing wrote to all staff members highlighting the correct process. In terms of medication.	• All relevant staff members have been made aware of the correct process in relation to medication.
Bedford Ward	A risk assessment was undertaken following a trend of violence and aggression incidents which were highlighted on Bedford Ward.	• Task and Finish Group was put in place to support number of issues identified in Bedford in relation to the violence and aggressive incidents	• Action plan was developed and this was monitored via the Task & Finish Group.

Division: Family Health – Neonatal Services

Serious Incidents			
Location	**Incident overview**	**Learning identified**	**Outcome**
NICU	Untreated hypoglycaemia	• Understanding of the hypoglycaemia pathway	• Revised guideline • Lesson of The Week for all staff
Labour Ward	An unexpected admission to the neonatal unit with possible failure to recognize the deteriorating condition of a newborn baby.	• Human factors training	• Supervised practice for individual • Human factors training for the team • Communication skill training for individuals
NICU	Potential delayed diagnosis of Necrotizing enterocolitis, leading to periventricular leukomalacia.	• Some delays were identified in the response to the baby's deterioration during the early hours of 20th April 18. A more senior presence would have led	• Continue to expand Neonatal Consultant workforce to allow for 24/7 Presence. • Review the middle grade rota aiming to ensure the presence of an experienced

		to a more rapid response and stabilisation, probably with a telephone call to the surgical consultant shortly after the first x ray at 02:30. • There was a delay in transfer to Manchester after the decision to transfer was made. • Poor record keeping • Retrospective entries made by busy neonatal team • No entries made by surgeon	ANNP or post core ST4+ doctor on duty at all times. • Amend the Tier one rota to ensure that there are always two people on duty overnight. • Ensure that senior neonatal nurses feel able to escalate their concerns to a consultant when they are concerned about the response or workload of the Tier one and two teams. • Ensure that neonatal nurses feel able to perform a blood gas as part of their patient assessment when there is a delay in obtaining medical review and they have concerns about a patient's wellbeing. • Review the iv fluid policy to make it clearer that 10% dextrose should not be given as the only form of intravenous fluids except in the first three days of life in babies without surgical problems. • Continue to develop the "Single Neonatal Service" across LWH and AHCH. • Inform the neonatal transport service of concerns regarding delay in transfer, possibly relating to lack of dedicated ambulance support. • Ensure that parents of a baby who requires transfer are advised not to leave the unit to travel to another unit until their baby has been taken by the transport team.
NICU LWH/AH	From 30/11/2018 to12/12/2018 (the date of passing), the patient	• Importance of concise communication and	• Joint working with PICU to develop clear and safe communication systems.

	was transferred between Liverpool Women's Hospital and Alder Hey Hospital on a number of occasions, predominantly due to arising challenges in managing surgical lines	documentation to ensure the safety and effective delivery of care	• Multi agency conference calls • Care of the neonate outside the NICU environment • Education of staff on the PICU/NICU in relation to line care and placement. • Development of guideline to ensure standardisation of practise in relation to lines • Development of the Liverpool Neonatal Partnership
NICU	Umbilical venous catheter (UVC) inserted into preterm baby and was in a sub optimal position on multiple x-rays. May have led to a Total Parenteral Nutrition extravasation injury into the peritoneum, as there was an acute deterioration of the baby with abdominal distension and assumed parenteral nutrition withdrawn from abdomen. Peritoneal drain inserted by surgeons from external children's hospital	• Ensuring all staff are aware of the correct positioning of central line	• Lesson of the week issued in June 2019 regarding correct position of UVC. • Individuals involved in decision that the line was to stay in suboptimal position have been fed back to regarding this potentially incorrect practice

General Incidents			
Location	**Incident overview**	**Learning identified**	**Outcome**
NICU	Medicine incidents	• Incidents in relation to administration and prescribing	• A robust process using a Medicines error tool is use on the NICU. This is used for both the administration and prescribing errors on the unit and provides a standardised way in dealing these errors.

NICU	Breast milk errors	• The need for breast milk to be treated like a medicine	• Lesson of The Week published • Introduction of the Infant feeding team • Working with the Trust to procure a barcode system to help reduce errors
NICU	Radiology –poor reporting and documentation of reviewed x-rays	• Need for new SOP	• Lesson of The Week published • New SOP introduced and used by all the medical team

Division: Family Health –Maternity Service

Serious Incidents			
Location	**Incident overview**	**Learning identified**	**Outcome**
Maternity - MLU	Intrapartum Stillbirth	• Raise awareness to ensure any requests for bleeping medical teams are appropriate to the clinical situation and that the request is clear, concise, understood and has been actioned • All midwifery and obstetric staff to attend the Multi-Professional Maternity Emergency Training focus on Human Factors, integrated multi-professional working, emergency skills & drills and debrief which focuses on the performance of the team to achieve improved patient safety outcomes • Ensure that all staff are aware of the clinical indications to utilise the Emergency Room • Individual feedback and wider dissemination with regards to foetal auscultation, use of vaginal	• LOTW is on display across all areas across Maternity. • Learning Lessons is uploaded to Trust Intranet. . • Provision of CPAP at delivery box • Installation of telephone in Emergency Room on MLU • All midwifery and obstetric staff to attend the Multi-Professional

		examination documentation aid and undertaking full assessment prior to commencement of active pushing • Review the Latent Phase of labour guideline with specific focus on analgesia including non-pharmacological and opioid analgesia • Neonatal resuscitation training to include discussions surrounding clarification of request and confirmation of drugs during resuscitation	Maternity Emergency Training, (MPET) focus on Human Factors, integrated multi-professional working, emergency skills & drills • Communications to all staff regarding indications to utilise the Emergency Room • Guideline review completed. Introduction of new non pharmacological in labour guideline. • Neonatal resuscitation training to include discussions surrounding clarification of request and confirmation of drugs during resuscitation
Maternity – Delivery Suite	Therapeutically cooled infant – Diagnosis of HIE Grade 3.	• Feedback and support for training for individuals involved • Development of a multidisciplinary team Human Factors training • Allocated time to be given to clinical staff to complete K2 competency	• Development Plan completed. • Midwife now providing intrapartum care. Reflects regularly on practice. No further problems identified. • OBS 4 study day planned until 2020. Staff given option of OBS 4

		• Review IOL policy and lesson of the week to all staff on importance of cervical assessment prior to reinsertion of cervical induction agents • Review of K2 monitoring system for ongoing CTGs to all be displayed on the K2 monitor in handover room to allow for a helicopter view of all CTG • Review of process for placental investigations	attendance or completion of Mandatory CTG Training on K2 in own time with 8 hours provided for Study Leave. • Large screen in handover office on DS available. • MLU also have an overview screen to enable CTG overview in the case a patient requires Continuous CTG.
Maternity – Delivery Suite	Intrapartum Stillbirth of Pre Term Twin.	• Adapt the extreme prematurity pathway to ensure clearer documentation that captures the ongoing discussions regarding parental wishes for management • Review management of extreme preterm twin. I) Consultant Lead is assigned ii) On Call Consultant to be involved in parental discussions • Where possible, multidisciplinary team discussion should take place prior to joint review with parents • Preterm Birth guideline, should be read and acknowledged by all labour ward staff to ensure they understand current guidance • CTG teaching to include interpretation of preterm CTG • Feedback and support to be provided to i)medical team involved ii) midwifery team involved, including discussion of report and human factors training • Review of K2 training status for staff involved in incident. Support staff for further training if indicated	• Adapt the extreme prematurity pathway to enable clearer documentation to capture the ongoing discussions regarding parental wishes for management. • Management of twin extreme preterm births should be Consultant led and any changes in parental decisions should be discussed with the Consultant on call • Multidisciplinary team discussion with Neonatologists should occur prior to discussions

			with the parents to gain the full picture • Obstetric and Neonatology teams to complete Extreme Prematurity Pathway together • Education and training surrounding the management of preterm labour. • Regional Preterm Birth guideline has been published. All labour ward staff to read and sign to ensure they are up to date with pre-term labour management • Local CTG teaching to include CTG interpretation of preterm CTGs
Maternity – Delivery Suite	Therapeutically cooled infant – Diagnosis of HIE Grade 3.	• Monitoring of completion rates for fetal monitoring training and competency package and a plan is in place to improve compliance • Review of mentorship for newly qualified midwives/new starters • Feedback to staff involved in the case • Medical review to be undertaken in the room and documented in the woman's notes following two consecutive suspicious CTGs	• Monthly review of K2 training figures, reported to Intrapartum Matron. • New starters have a period of supernumerary, named mentor in clinical area, badge that identifies them as a new member of staff. Full OBS day attendance

		• Introduction of safety huddles, which will take place on all days of the week halfway between each of the full handovers • Review need for equipment checklist • Ongoing audit of cases of missed small for gestational age	and 18-month preceptorship programme. PMA programme implemented and staff access support as and when needed, • All Midwifery and Obstetric staff have attended MMPET training session, which includes human factors and situational awareness as per the CNST safety action plan. • Foetal monitoring guideline up to date. • Huddles introduced and communication to appropriate staff, challenges identified about formalising process and recording evidence.
Maternity – Delivery Suite	PPH 3.5 litres. Transfer to RLUH and diagnosis of AKI.	• Explore the current process for reviewing maternal antibodies with the development of a pathway for maternally significant antibodies. (This will require input from the haematology team at the RLUH) • Consider the feasibility of providing O negative blood, free of specific antibodies, during periods when high-risk women are due to deliver. • Support the clinicians involved in this case and allow them to attend appropriate mandatory training or courses in the management of post-partum	• Training dates provided to staff member • Staff involved have attended training • Maternity Skills and drills in accordance with both the PPH & Retained placenta Guidelines (as noted in the Incident the midwifery staff were

		haemorrhage. They should provide evidence to support completion of training. • Provision of human factors training to staff involved in maternity care. • Improve clinical awareness of the maternal significance of maternal antibodies through utilisation of training days available at the trust. (Great Day, Back to Breakfast, Registrar Teaching) • Seek assurance that mandatory training in relation to management of PPH is up to date. Confirm that the programme covers areas of concern from this review. • Review the provision of simulation training and development a programme for the maternity simulation. • Provide an update to the guideline for the management of PPH with the addition of an SOP for the after care of major obstetric haemorrhage. • Consider the development of an SOP for patients receiving O negative blood – to liaise with haematology to verify feasibility. • Review the process for step down from HDU to the maternity ward with improved communication in relation to ongoing care plans. • Improve how the clinical team on DS are updated in relation to the high-risk PN patients.	aware of the correct management for PPH) • Some actions still ongoing
Maternity - MLU	Therapeutically cooled infant after Outpatient IOL	• Review the process for recording maternity triage calls with current IT systems • Feedback to all staff involved in the incident, highlighting the need to complete full antenatal examination to ascertain if in established labour • Installation of communication board for outpatient induction of labour on the MLU	• LOTW to be shared with all staff to remind them of the importance of direct communication and listening to patient concerns • LOTW to be shared with all staff regarding the

		• Review Induction of labour guideline with specific focus on outpatient induction of labour criteria and place of birth.	importance of contemporaneous documentation • Communication board for outpatient induction of labour on the MLU in place. • Guideline review ongoing.

General Incidents including 72 hour reports, HSIB and Formal Reviews. All general incidents (for the purpose of this template - formal reviews in Maternity 2019) are monitored through an Action Tracker on a monthly basis at the Maternity Risk Meeting.			
Location	**Incident overview**	**Learning identified**	**Outcome**
Maternity – Delivery Suite	Baby admitted to NICU in critical condition following spontaneous vaginal birth in ambulance transfer to LWH from Home after planned home confinement.	• Ensure that Junior medical staffs are able to give good quality, informed information when a patient declines treatment. • Ensure escalation to Consultant in cases of refusal of IOL in high-risk patient.	• Reported to HSIB – awaiting full report. • Staff involved given support
Maternity – Delivery Suite	Late diagnosis of Cervical Cancer in Pregnancy.	• Lack of recognition of the significance of raised ferritin levels • Need for senior review for women with repeat attendances at MAU	• Updated anaemia guideline with regards to raised ferritin levels

		• Indications for escalation when speculum examination incomplete	• Case to be used in Junior Doctor teaching regarding speculum examinations – indications, technique, escalation • Process for senior review of women with >2 admissions to MAU to be reviewed • Reflection by staff members
Maternity – Obstetric Theatre	Emergency CS 36+6. Abnormal CTG. Therapeutically cooled baby.	• Lack of documentation and routine observations in antenatal inpatients • No evidence of maternal observations, fluid balance charts, Visual Inspection Proformas (VIP) for more than 12 hours. • False reassurance of computerised CTG analysis, with no visual inspection and interpretation of the CTG taking into consideration the clinical situation of an unwell patient • Culture of ward round - Not all information are available when reviewing patients • Poor communication between ward and staff in DS of unwell patients in the ward	• Action Plan formulated and completion ongoing. Monitored through Maternity Risk Meeting.

Maternity – Delivery Suite	Whilst inpatient on Delivery Suite with epidural anaesthesia in situ, patient sustained severe burn to inner left thigh from hot water bottle leak. Blisters and redness noted to skin.	• Lack of guidance available for use of hot water bottle in Maternity • Failure to document the use of hot water bottle in medical records. • Lack of identification of injury and actions taken to treat. • No escalation to Medical staff regarding burns injury.	• Standard Operating Procedure developed for use of Hot Water Bottles.

Division: Clinical Support Services

Serious Incidents			
Location	**Incident overview**	**Learning identified**	**Outcome**
The Division has had no SI's since its creation in April 2019. Association with Some SI' covered by other Divisions.			

General Incidents			
Location	**Incident overview**	**Learning identified**	**Outcome**
Access Centre	Lack of ability to get in contact with access centre staff	• Improvements required to current phone system to allow call waiting and message	• Phone system been updated to allow a holding message to be heard by patients.
Administration (Gynaecology/Maternity/Oncology)	Lack of /or poor communication	• Poor customer care skill of staff • Lack of standardised communication process	• New staff training in relation to customer care being implemented

	Incorrect / or delayed correspondence Inability to make phone contact.	• Review of correspondence system required • Increase capacity for dealing with phone calls and ability for a call waiting system.	• Standardised approach to call answering across trust being reviewed. • Administration management team working to improve correspondence processes • New centralised call centre created to allow for cross cover between admin staff.
Theatres	Cancellations of patient theatre slots on / or close to the day of operation.	• There are a number of different reasons patient are cancelled, some are patients own choice due to change of mind on the day etc. • Patient cancelled due to complex case overrun • Some cases of cancellation due to sickness and lack of spare capacity • Some cases of cancellation due to poor theatre planning process and list overbooked.	• All cases are reviewed for reason • Theatre Operational group in place to plan sessions • Safety huddle in Theatre in the morning before Theatre session commence • Active staff deployment in Theatres as required

Liverpool Women's NHS Foundation Trust

Agenda Item	2019/172

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Freedom to Speak Up - Self Assessment**
DATE OF MEETING:	Thursday, 07 November 2019
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Michelle Turner, Director of Workforce and Marketing
AUTHOR(S):	Michelle Turner/ Chris Mcghee
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☐ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☒

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☐	**4.** NHS Constitution ☒ **5.** Equality and Diversity ☐ ***6.*** Other:
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board of Directors is asked to*** • ***accept the assurance provided with respect to the compliance/ progress to date against the national guidance for Freedom to Speak Up processes;*** • ***note the actions outlined to improve compliance*** • ***note that the draft Strategy will be considered at the next Board Workshop and a future Listening event prior to Board approval***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable
	Date of meeting	

Executive Summary

In July 2019, the National Guardian's office published Guidance for Boards on Freedom to Speak Up processes.

The Trust's Freedom to Speak Up Guardians have used the guidance and the attached toolkit to help the board identify its current position with respect to Freedom to Speak Up and the actions required to fully meet the expectations of NHS England and NHS Improvement and the National Guardian's Office. The attached document sets out the Trust's current position, identifies any gaps and the actions planned to move towards full compliance. Progress against the Action Plan will be monitored by the People Committee on behalf of the Board of Directors.

A Draft Freedom to Speak Up strategy has been developed which sets out the Trust's ongoing commitment to creating a culture where staff can speak out in confidence The Board of Directors will have opportunity to consider and input into the draft strategy at its workshop in January prior to formal approval. The draft strategy will also be shared with staff side colleagues and will be the subject of a Listening Event with a wider cohort of staff in advance of its formal adoption and publication.

The Trust will use this toolkit to regularly review its progress and will include this update in the bi-annual report to the People Committee and Board from the Freedom to Speak up Guardians.


Freedom to Speak Up toolkit Self Asses


F2SUG Action Plan.docx

Recommendation

The Board of Directors is asked to

- ***consider the assurance provided with respect to the compliance/ progress to date against the national guidance for Freedom to Speak Up processes;***
- ***note the actions outlined to improve compliance & ask the People Committee to monitor progress on its behalf***
- ***note that the draft Freedom to Speak Up Strategy will be considered at the next Board Workshop and a future Listening event prior to Board approval***

Freedom to Speak Up review tool for NHS trusts and foundation trusts

July 2019

How to use this tool

This is a tool for the boards of NHS trusts and foundation trusts to accompany the *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with page numbers in the tool) *and the* *Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with section numbers).

We expect the executive lead for Freedom to Speak Up (FTSU) to use the guidance and this tool to help the board reflect on its current position and the improvement needed to meet the expectations of NHS England and NHS Improvement and the National Guardian's Office.

We hope boards will use this tool thoughtfully and not just as a tick box exercise. We also hope that it is done collaboratively among the board and also with key staff groups – why not ask people you know have spoken up in your organisation to share their thoughts on your assessment? Or your support staff who move around the trust most but can often be overlooked?

Ideally, the board should repeat this self-reflection exercise at regular intervals and in the spirit of transparency the review and any accompanying action plan should be discussed in the public part of the board meeting. The executive lead should take updates to the board at least every six months.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But getting the FTSU Guardian's views would be a useful way of testing the board's perception of itself. The board may also want to share the review and its accompanying action plan with wider interested stakeholders like its FTSU focus group (if it has one) or its various staff network groups.

We would love to see examples of FTSU strategies, communication plans, executive engagement plans, leadership programme content, innovative publicity ideas, board papers to add them to our Improvement Hub so that others can learn from them. Please send anything you would specifically like to flag to nhsi.ftsulearning@nhs.net

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
Behave in a way that encourages workers to speak up					
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Section 1 p5	Partially	16/09/19	The executive team have commissioned a 5 year project to embed cultural change, with each director taking responsibility and leadership for their areas of control. This will develop a supportive and compassionate leadership. (Fair & Just Culture) Kindness and Respect campaigns in design which will require each director to make a public pledge to be kind and role model high standards of conduct. There are no restrictions placed on the role of F2SUG within the Trust, F2SUGs are able to engage with staff freely and support across a wide range of issues. By having a clinical and non-clinical F2SUG the skill mix in the team means that there is good understanding and support. Trust wide learning systems are being improved as part of the Fair and Just culture project to improve Trust wide learning.	Systems for monitoring changes as a result of the F+J Culture project are in development, this will enable oversight of decisions, empathy and learning across a range of systems, Appraisal, sickness, recruitment and termination processes. Fair and Just culture project in year 1 of 5, led by F2SUG as this role is autonomous within the Trust and has the trust of staff. No formal processes for triangulation of intelligence. F2SUG have access to all systems but have not yet developed the systems for formal evaluation.
Demonstrate commitment to FTSU					

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and non-executive leads responsible for speaking up • speaking up and other cultural issues are included in the board development programme • they welcome workers to speak about their experiences in person at board meetings • the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made • the trust continually invests in leadership development • the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.	p6 Section 1 Section 2 Section 3	Partially	16/09/19	Named Executives and Non Executives for Speaking up Board development program includes, Speaking up and Fair and Just culture development program. Focus for this year has been Fair and Just culture knowledge and strategy. Workers attend PPF committee, to share their stories with Board Members and Exec and Non Exec for Speaking up. Investment into a 5 year program for improving the Trust culture using Fair and Just Methodology and led by F2SUG. The Trust has an internal leadership program, and Aspiring Talent Program for leadership, the F2SUG speaks on the leadership program.	There are no formal processes to review claims of detriment; this is currently an informal process. Formal processes to evaluate F2SUGuardian need to be strengthened. Currently there is bi-annual reports to People Committee/Board and regular 1:1 meetings with Executive Director. Meetings with Chair, Non Exec Lead for Speaking up and Chief Exec to be formalised. The Trust has difficult in sharing and promoting stories of successful speaking up due to it being a small Trust with easily identifiable services and individuals Exploring sharing positive stories across a network of guardians in the area to provide for anonymity..
Have a strategy to improve your FTSU culture					

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	P7 Section 4	Partially	16/09/19	F2SUG Strategy has been developed and is currently in draft. The draft Strategy is due to go to the Board workshop for Board input and comment in January and will be approved by Board in February 2020 The Board is regularly updated by the Exec Lead and via the minutes and reports from PPF committee	The People Committee will regularly review progress against the Strategy and other national measures of performance, and provide assurance to the board at least twice a year
Support your FTSU Guardian					
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively	p7 Section 1 Section 2 Section 5	Partially	16/09/19	The Executive Team invested in a second F2SUG in 2018, to support the first F2SUG. This doubled the amount of time available to Guardians. This is monitored via Monthly meetings with Exec Lead. Both F2SUGs within the Trust have completed training and ongoing development appropriate to their role as F2SUG.	Current ad hoc meetings with Chair, Non Exec Lead for Speaking up and Chief Exec will be formalised. No formal processes for triangulation of intelligence, F2SUG have access to all systems but have not yet developed the systems for formal evaluation.

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• the Guardian has been given time and resource to complete training and development • there is support available to enable the Guardian to reflect on the emotional aspects of their role • there are regular meetings between the Guardian and key executives as well as the non executive lead. • individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner • they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes • the Guardian is enabled to develop external relationships and attend National Guardian related events				The F2SUG meet weekly to review caseloads, and emotional issues relation to Guardian work, this is a supportive peer to peer meeting. F2SUG have access (if and when required) to formal restorative supervision, this process was agreed in 2019 and has not yet been tested. The F2SUGs meet monthly with Exec Lead All Executive support the role of the F2SUG and support escalation where appropriate. F2SUG are able to escalate to any Director or NED. The F2SUG have unlimited access to anonymised data as they require it however there are no formal processes in place for triangulation of data. Trust Guardians attend regional and nation events and are encouraged and supported to do so.	
Be assured your FTSU culture is healthy and effective					
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate:	P8 Section 8 National policy	Partially	16/09/19	The Speaking up policy is due for a review and is in the F2SU strategy. When written 4 years ago (reviewed 1 year ago) it met the standards set out at the time.	Policy review due and will come to PPF for approval. The Trust need to develop and audit and quality assurance process for speaking up and F2SUG activity. Then produce Gap

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• that the policy is up to date and has been reviewed at least every two years • reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.				The F2SUG produce a twice annual report to PPF on the number, type, nature and origin of all concerns raised and the outcomes and feedback from staff that have raised concerns. This includes any trends and areas of concern	analysis to inform future developments of the F2SUG
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance • assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances • you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection • you evaluate gaps in assurance and manage any risks identified, adding	P8 Section 6	Partially	16/09/19	The F2SUG report annually to the Board, in written and verbal formats. These reports contain information on number and themes of speaking up; feedback information ; Staff Survey information; The F2SUG read and share learning from Case Reviews carried out by National guardians Office The Fair and Just culture program is linked to development of assurance as it is led by the F2SUG, the book clubs are an informal way to learn about the culture from staff in a safe way. This learning inform the program development. The F2SUG are interviewed as part of the Well Led aspect of CQC inspections	In 2019 the reports will be developing to include case reviews No formal processes for triangulation of intelligence, F2SUG have access to all systems but have not yet developed the systems for formal evaluation. HR processes being reviewed as part of Fair and Just culture program and exit interviews will include F2SUG as an option for staff. No formal process in place for collection of feedback from Board Workarounds

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
them to the trust's risk register where appropriate.					
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	P8 Section 7	Full	16/09/19	The F2SUG attend Board twice yearly and produce a written report that includes all cases of speaking up, including informal contacts, trends and themes. F2SUG attends PPF committee quarterly and produces updates on F2SUG and Fair and Just Culture.	
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	Section 1 NGO JD	Full	16/09/19	The recruitment of the past 2 F2SUG has been through an open recruitment process and the JD and Guidance from the National Office is evidenced.	
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	Section 7	Partially	16/09/19	Gap analysis it completed by F2SUG and learning shared	To be included in existing regular F2SUG reports to people committee and escalaed to board via Chairs Report.
Be open and transparent					
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion with relevant oversight organisation	P9			F2SUG bi-annual reports discussed in public Board meeting. Good engagement with National Guardian's office who have previously visited the Trust.	To publish F2SUG Annual Report on website To make appropriate reference to Freedom to Speak Up in Annual Report

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• discussion within relevant peer networks • content in the trust's annual report • content on the trust's website • discussion at the public board • welcoming engagement with the National Guardian and her staff					To widely promote within the organisation the positive actions taken as a result of 'speaking out' using case studies wherever possible.
Individual responsibilities					
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	Section 1			Currently appraisal require evidence of compliance with Trust values but does not specifically address Freedom to Speak Up	Appraisal documentation to be expanded to prompt positive action around Freedom to Speak Up and evidence of performance/compliance.

F2SUG Action Plan – 2019- 2021

	On target to achieve		*Minor Delay*		*Behind Schedule*		*Completed*

Action 1 **Raising the Profile of Speaking up**	**Action Description**	**Lead**	**Target Date**	**Progress / Completion**	**RAG**
a) Identify the baseline for knowledge of speaking up across the Trust – use the intelligence gathered to inform future engagement with staff.	F2SUG walk around the Trust at least quarterly and speak to a minimum of 30 staff, complete a short Q+A and ascertain their knowledge of Speaking up arrangements at LWH	**KR**	**January 2020**		
b) F2SUG to work at Regional and National Level to celebrate and inform speaking up	Attend quarterly Reginal events including Regional conference Read and review Bulletins from NGO and share any relevant information	**Both**	**Ongoing**		
c) Read and Evaluate the Case Studies produced by the NGO	Develop a gap analysis and action plan for improvement on LWH current performance and development needs in relation to Case Studies. Report findings, developments to PPF in bi annual report.	**KR**	**December 2019**		

	Escalate any urgent issues to Executive and NED for Speaking Up				
d) Development of a quarterly Divisional Reports to raise the profile of speaking up at Divisional level.	Identify the • Number/ type of concerns raised per division per quarter. • Response time • Learning achieved • Areas of concern for Guardians • Silent areas • Survey results of F2SUG walkabouts • Team meetings attended, other engagement and education events attended.	**CMcG**	**March 2020**		
e) Ensure the Trust Policy on Speaking up reflects the best practice National Speaking up Policy Guidance	Review current policy against National Speaking up Policy Guidance Undertake Gap analysis Revise policy to reflect national guidance Ratify policy via usual channels	**KR**	**March 2020**		
f) Ensure all Trust Induction Sessions have a spot for the	Review all Trust induction programs and ensure F2SUG are represented on	**KR**	**March**		

F2SUG role and Speaking Up at LWH	each one including student nurse/midwife and Junior Doctor Induction programs. Ensure promotional materials are available in induction packs		**2020**		
g) Gap analysis of current training program against National Guidelines on Speaking up Training from NGO	Review the F2SUG input into the Trust Leadership program to ensure it is up to date and congruent with national best practice. Ensure the training program for staff meets the minimums standards of the NGO Guidance. Development of on line and virtual training programs to promote learning.	**CMcG**	**April 2020**		
h) Development of closer links with other staff support services such as Mental Health First Aiders and Dignity at Work Advisors	Support the development of a comprehensive advice system for all staff. Support other internal staff support services and engage in greater cross	**CMcG**	**April 2020**		

	working				
i) Develop ways to celebrate speaking up across the Trust and externally	Celebrate annual Speaking up Month (October) have plans in place to raise the profile of speaking up Develop (where appropriate) lessons learnt from speaking up cases within the Trust, maintaining confidentiality.	**KR**	**October 2020**		
j) Regular meetings between the F2SUG's and CEO, Chair, NED and Exec for Speaking up are diarised	Ensure meetings are regular and given priority within diaries	**CMcG**	**April 2020**		
Action 2 **Development of a comprehensive Data set**	**Action Description**	**Lead**	**Target Date**	**Progress / Completion**	**RAG**
a) Development of a minimum Data set for reports to Board and PPF which will provide assurance about the Speaking up arrangements in the Trust	Ensure compliant with NGO advice in Guidance for Boards on F2SU in NHS Trusts and NHS Foundation Trusts (July 2019). Ensure data set is triangulated properly to give informed advice to Board and PPF Agree with Trust Secretary frequency	**CMcG**	**April 2020**		

	of reports to Board and PPF				
b) Development of a feedback mechanism to allow learning, improvement and development of the F2SUG service	Design a feedback / evaluation form for all contacts for the F2SUGs within LWH to include • Ease of use • Response times • Attitudes • Support Offered / Given • Detriment • Overall Satisfaction • Use again? Ensure this feedback is added to the annual F2SUG reports to PPF and Board	**CMcG**	**March 2020** **With review** **October 2020**		
c) Annual Self-Assessment against national best practice to be developed	To be completed annually and action plans developed for any areas of non-compliance with expectation.	**BOTH**	**Annually with Trust secretary**		
d) Development with HR leads a system to review impact of speaking up on workforce	Review current arrangements and revise the information this is telling us. To include :- • Sickness • Recruitment • Termination • Exit Interview • Staff Survey results	**KR**	**September 2020**		

Action 3 Review of current training and Information on Speaking up within LWH	Action Description	Lead	Target Date	Progress / Completion	RAG
Review of all Promotional Materials	Review current promotional materials, cross reference with survey responses (above) and refresh and develop new methods of promotion of Speaking Up across the Trust. Development of a Trust Leaflet on Guidance about How to speak up and How to receive a concern at LWH.	**CMcG**	**Sept 2020**		
Attend all induction programs	Identification of all induction programs, frequency and leads Ensure inductions are diarised into F2SUG diaries Review induction packs for F2SUG information and revise any gaps	**KR**	**Sept 2020**		
Development of an online training program in how to raise and receive a concern.	Working with Learning and Development Leads, IT leads; NGO and Regional Guardians develop a	**Both**	**Dec 2020**		

	comprehensive on line training program for all staff. Develop an evaluation process for evaluation of learning Build in annual reviews				

Liverpool Women's NHS Foundation Trust

Agenda Item	2019/173

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**
DATE OF MEETING:	Thursday, 07 November 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)?*** **1.** To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☐ **2.** To be ambitious and ***efficient*** and make the best use of available resource ☐ **3.** To deliver ***safe*** services ☒ **4.** To participate in high quality research and to deliver the most ***effective*** Outcomes ☐ **5.** To deliver the best possible ***experience*** for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care,* ☒

	supports learning and innovation, and promotes an open and fair culture. ***ALL DOMAINS*** ☐	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☒	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: **NHS England Compliance**
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to note: • The content of the report and be assured appropriate information is being provided to meet the national and local requirements. • The organisation has the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Director of Nursing & Midwifery	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable
	Date of meeting	

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 June and July 2019 remained appropriate to deliver safe and effective high-quality family centred patient care day and night.

Ward Staffing Levels – Nursing and Midwifery
Report August and September 2019

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 and 2) 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 **August and September 2019.**

- Gynaecology has seen an slight decrease In August but an increase in September.
- Delivery suite and maternity base have seen an increase in fill rates for RM and care staff from August to September.
- MLU and Jeffcoate has seen a decrease in RM from August to September in overall fill rate
- Neo- natal has remained static with RN fill rate but has seen a drop-in care staff between August and September.

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. It should be noted that Jeffcoate ward is sometimes closed due to staffing and they are re-deployed to other areas in maternity.

2.2 Red Flags

In August and September 2019 there were 84 red flags reported. Out of these 12 were for 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 midwives in the NHS in England.

It should also be noted that with one to one going into administration in Liverpool this has had and will have a further impact on maternity services at LWH. Following a comprehensive review of the additional activity it is apparent that 252 women who have elected to transfer care to LWH, and of that number 242, intend to birth at LWH. A risk assessment of each of these women has been undertaken and it has been established which clinical pathway is required. 19 are intermediate, 69 intensive and the remaining, 154 being low risk, so this changes the staffing profile required to care for these women.

This will require 9 additional midwives and 2 additional support staff to care for these women.

4.0 Vacancies-

Not including the increased requirement following the one to one closure, there are currently 6 vacancies across Maternity with 9.5 wte in the recruitment process to start. 2 Band 5 WTE vacancies on the Gynaecology Ward. 5 wte band 5 and 4 wte band 6 vacancies in theatres. 8 wte band 5 vacancies in Neonates. There are robust recruitment plans to appoint into these posts.

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 NMPF 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. Each division undertakes health roster challenges led by HON/M.

5.0 Summary

During the month of **August and September 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

August 2019

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	91.1%	75.3%	100%	100%
Delivery Suite	91.2%	79.6%	91.7%	77.4%
Mat Base	89.5%	79%	89.9%	77.4%
MLU	101.6%	167.7%	81.5%	80.6%
Jeffcoate	100%	100%	100%	78.6%
Neo-nates	107.1%	112.9%	110.3%	100%

September 2019

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	107.1%	76%	111%	100%
Delivery Suite	91.7%	96.6%	90.5%	73.3%
Mat Base	173.4%	73%	154%	82%
MLU	89.2%	100%	68.3%	140%
Jeffcoate	96.7%	93.3%	100%	76.7%
Neo-nates	108.5%	95%	109.2%	83.3%

Liverpool Women's NHS Foundation Trust

Agenda Item	2019/174

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Performance Report Month 6 2019/20**
DATE OF MEETING:	Thursday, 07 November 2019
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Gary Price, Director of Operations
AUTHOR(S):	Gary Price, Director of Operations
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☒ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS*** ☒

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☐	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: Click here to enter text.
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the report.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee Governance and Clinical Assurance Committee
	Date of meeting	Monday, 21 October 2019

Executive Summary

This report has been produced to provide a performance position for month 6 and for the Trust Board to be assured of the measures taken to address the patient access targets.

In month 6 the 18-week Referral to Treatment (RTT) target increased for a 3rd consecutive month, although continued performance improvements are dependant on maintaining clinical capacity to meet demand.

Oncology performance remains a significant challenge, largely due to reduced clinical capacity. Whilst the 2-week target for suspected cancer referrals was again delivered in month 6 the 31- and 62-day target were not.

Report

1. Introduction

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

2. Performance

INDICATOR		METRIC	THRESHOLD		ACTUALS						Δ
					Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	
Cancer	2WW for suspected cancer	%	≥93%	Higher values are better	94.2	97.7	93.3	95.0	*93.9*	*96.23*	▲
	31 Days from Diagnosis to 1st Definitive Treatment	%	≥96%	Higher values are better	83.3	90.3	60.0	70.3	*59.1*	*28.5*	▼
	62 Days for First Treatment from urgent GP Referral **(After re-allocation)** Final Reported Position	%	≥85%	Higher values are better	54.3	80.9	22.2	32.3	*33.3*	*28.5*	▼
	104d Referral to First Definitive Treatment	Count	0	Zero tolerance	0	1	3	0	*1*	*7*	▲
RTT	RTT Incomplete Pathways <18 weeks	%	≥92%	Higher values are better	84.6	83.0	81.5	81.95	*83.0*	*83.3*	▲
	Incomplete Pathway > 52 Weeks	Count	0	Zero tolerance	6	3	3	1	*1*	*1*	►

2.1 RTT

RTT incomplete 18-week pathway performance increased in September to 83.3 %. This was the 3rd consecutive in month increase and was broadly in line with the planned trajectory (83.5%).

There was 1 52-week breech for September due to failure in administrative processes in May 2019. the patient has been clinically seen subsequently and discharged.

The focus continues to be aimed, in line with NHSI guidance, on prioritising treating those clinically urgent, longest waiting patients for in both our admitted and non-admitted RTT pathways. RTT training for staff continued through September and will conclude in November 2019. The Trust will recommence the RTT weekly submission to the CCG and NHSI&E in November due to greater confidence in data quality.

Through the end of September and continuing in October there has been sickness and absence in the Consultant workforce resulting in an unplanned pressure on the service.

2.2 Cancer

Cancer performance remains a significant concern for the Trust with long term sickness within the speciality and vacancy. Whilst the 2-week target is maintained the 31- and 62-day targets were not met in September. There were 10 reported 62-day breeches for month 6.

- 4 were due to late referrals from other Trusts (due to the nature of breech allocation these are split equally between LWH and referring Trusts and therefore reported as 2)
- 3 of these were due to lack of surgical capacity within the Trust
- 2 of these were due to lack of critical care capacity
- 2 were due to diagnostic capacity
- 1 patient was unfit for surgery

Of the 62-day breeches, 7 are also reported as 104-day breeches in September. All 104-day breeches have harm reviews. 4 of these were the above late referrals from other Trusts, 1 patient unfit for surgery, 1 lack of critical care capacity and 1 due to diagnostic capacity.

For Q2 2019/20 the Trust cancer performance is:

2 week wait (target 93 %)	95.05%
31-day decision to treat (target 96%)	54.55%
62-day treatment (target 85%)	30.99%

The service has a medical establishment of 6. At present there are 3 Consultants in post due to vacancy and sickness. One of the 3 is due to leave the Trust in January 2020.

Regional escalation through the Cancer Alliance, NHSI and E and Liverpool CCG has taken place. The strategic view of the Trust is that cancer targets will remain a challenge whilst services are not collocated with appropriate surgical, critical care and diagnostic support. A formal partnership board with Liverpool University Hospitals is being established to attempt to address these issues.

In addition to the strategic actions the service is focussing operationally to mitigate wherever possible the reduced workforce. This is managed via a weekly Executive lead oncology action plan meeting.

The themes for local operational action are all based around maximising the existing resource to support the service and our patients. CCG and other commissioning colleagues are encouraged to attend these meetings in a partnership approach and have done. The key themes are:

1) Ongoing review of all patient pathways to reduce breeches, escalation of pathway delays (diagnostics including pathology).
2) Delivering combined theatre lists with Liverpool University Hospitals.
3) Review of current capacity and demand: Updating Job Planning and continue to try and recruit.
4) Recruitment to a dedicated cancer manager post is underway.
5) Decompression of service: working with the Cheshire and Merseyside Cancer alliance to reduce pressure on the service through pathway redesign.
6) Co-location of all the cancer team (administrative and clinical) with increased funding secured for cancer support workers.

As per the NHS Long Term Plan the Cheshire and Mersey Cancer Alliance will now be held to account for improving cancer performance with a view to addressing the regional failure to achieve the 62-day target. The Trust is engaged in this work which began in September. This proposes to move to a system level cancer improvement plan.

2.3 Sickness Absence Rates

KPI ID	Source	Service	Target < or >	Target	Value	Trend	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Sickness Absence Rate		Owner - Deputy Director of Workforce													
KPI101T	NHSI	Trust	<=	4.5%	Numerator		2080	2093	2278	2162	2083	1700	2041	2321	1989
					Denominator		39868	36383	40680	39457	41042.01	39805	41056	39241	38077
					Performance		5.22%	5.75%	5.60%	5.48%	5.07%	4.27%	4.97%	5.92%	5.22%
					Trend		▲	▲	▼	▼	▼	▼	▲	▲	▼
					Target %		4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
					Qtrly Performance		5.52%	5.52%	5.52%	4.94%	4.94%	4.94%	5.37%	5.37%	5.37%

Sickness improved in month 6 although remains below target. 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 also 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.

The NHSi Sickness Improvement project is now being incorporated as part of the Health & Wellbeing Group. They are developing a calendar of health & wellbeing events throughout the year, and they also looking at how we record and audit return to work interviews to ensure that they are happening in a timely manner.

3. Conclusion

18-week RTT performance continues to improve, however further improvement is still subject to appropriate capacity and the service continues to work hard to maintain those levels.

Oncology performance remains a significant challenge to the Trust, largely due to lack of clinical capacity and there are significant operational and strategic actions being undertaken to address this.

Liverpool Women's NHS Foundation Trust

Board Performance Report

Published Month - October 2019

Workforce

KPI ID	Source	Service	Target < or >	Target	Value	Trend	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Sickness Absence Rate	**Owner - Deputy Director of Workforce**																		
KPI101T	NHSI	Trust	<=	4.5%	Numerator		1620	1450	1917	2013	2080	2093	2278	2162	2083	1700	2041	2321	1989
					Denominator		38270	39929	38600	39871	39868	36383	40680	39457	41042.01	39805	41056	39241	38077
					Performance		4.23%	3.63%	4.97%	5.05%	5.22%	5.75%	5.60%	5.48%	5.07%	4.27%	4.97%	5.92%	5.22%
					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		4.20%	4.54%	4.54%	4.54%	5.52%	5.52%	5.52%	4.94%	4.94%	4.94%	5.37%	5.37%	5.37%
Mandatory Training Compliance	**Owner - Deputy Director of Workforce**																		
KPI095T	Quality Strategy	Trust	>=	95.0%	Numerator														
					Denominator														
					Performance		88.00%	86.00%	86.00%	85.00%	84.00%	84.00%	86.00%	85.00%	86.00%	88.00%	89.00%	89.00%	90.00%
					Trend		▼	▼	▶	▼	▼	▶	▲	▼	▲	▲	▲	▶	▲
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance														

Efficient

KPI ID	Source	Service	Target < or >	Target Value	Trend	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-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	9

Safety

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Never Events	**Owner - Head of Governance**																		
KPI181T	NHSI	Trust	=	0	Performance Value		0	0	1	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	1	1	1	0	0	0	0	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	
					Trend		▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0	0
Infection Control: Clostridium Difficile	**Owner - Infection Control Lead**																		
KPI104T	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**																		
KPI105T	Quality Schedule	Trust		0	Performance Value		0	0	0	0	0	0	0	0	0	1	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	1	1	1	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		3	2	3	1	1	2	1	1	2	2	0	0	5
					Denominator		717	697	666	704	689	595	659	649	659	662	692	699	689
					Performance		0.42%	0.29%	0.45%	0.14%	0.15%	0.34%	0.15%	0.15%	0.30%	0.30%	0.00%	0.00%	0.73%
					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		0.18%	0.29%	0.29%	0.29%	0.21%	0.21%	0.21%	0.25%	0.25%	0.25%	0.24%	0.24%	0.24%
Neonatal Deaths (All Live Births within 28 Days) - all live births	**Owner - Clinical Director Neonates**																		
KPI168b	Trust Objectives	Neonates	<=	6.1%	Numerator		4	2	3	1	1	2	1	1	4	2	0	0	5
					Denominator		719	703	680	715	698	597	665	656	673	668	699	753	698
					Performance		0.56%	0.28%	0.44%	0.14%	0.14%	0.34%	0.15%	0.15%	0.59%	0.30%	0.00%	0.00%	0.72%
					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		0.23%	0.29%	0.29%	0.29%	0.20%	0.20%	0.20%	0.35%	0.35%	0.35%	0.23%	0.23%	0.23%

Effective

KPI ID	Source	Service ID	Target < or >	Target Value	Trend	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Intensive Care Transfers Out		**Owner - Clinical Director Gynaecology**																
KPI107T	Trust Objectives	Trust		Performance Value		0	0	0	0	0	1	0	0	0	0	0	0	0
				Trend														
				Target Value														
				Qtrly Performance Value		0	0	0	0	1	1	1	0	0	0	0	0	0

Liverpool Women's NHS Foundation Trust

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
18 Week RTT: Incomplete Pathways		**Owner - Divisional Manager Gynaecology**																	
KPI003T	NHSI	Trust	>=	92.0%	Numerator		4615	4523	4580	4551	4481	4626	4715	4881	4973	5033	5117	5307	5310
					Denominator		5294	5193	5251	5298	5242	5452	5539	5769	5990	6173	6244	6396	6377
					Performance		87.17%	87.10%	87.22%	85.90%	85.48%	84.85%	85.12%	84.61%	83.02%	81.53%	81.95%	82.97%	83.27%
					Trend		▲	▼	▲	▼	▼	▼	▲	▼	▼	▼	▲	▲	▲
					Target %		92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
					Qtrly Performance		87.13%	86.74%	86.74%	86.74%	85.15%	85.15%	85.15%	83.02%	83.02%	83.02%	82.74%	82.74%	82.74%
18 Week RTT: Incomplete Pathway > 52 Weeks		**Owner - Divisional Manager Gynaecology**																	
KPI002T	Quality Schedule	Trust	=	0	Performance Value		12	15	14	11	5	3	3	6	3	3	1	1	1
					Trend														
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0	0
18 Week RTT: Admitted Completed Pathways		**Owner - Divisional Manager Gynaecology**																	
KPI001	Trust Objectives	Trust	>=	90.0%	Numerator		456	420	381	342	304	291	361	305	353	334	329	387	340
					Denominator		526	497	471	390	403	355	409	348	397	396	401	462	411
					Performance		86.69%	84.51%	80.89%	87.69%	75.43%	81.97%	88.26%	87.64%	88.92%	84.34%	82.04%	83.77%	82.73%
					Trend		▲	▼	▼	▲	▼	▲	▲	▼	▲	▼	▼	▲	▼
					Target %		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
					Qtrly Performance		88.62%	84.17%	84.17%	84.17%	81.92%	81.92%	81.92%	86.94%	86.94%	86.94%	82.89%	82.89%	82.89%
18 Week RTT: Non-Admitted Completed Pathways		**Owner - Divisional Manager Gynaecology**																	
KPI004T	Trust Objectives	Trust	>=	95.0%	Numerator		1450	1652	1817	1208	1834	1429	1508	1441	1786	1615	1681	1384	1619
					Denominator		1639	1830	2023	1312	2032	1576	1717	1598	2021	1869	1999	1617	1924
					Performance		88.47%	90.27%	89.82%	92.07%	90.26%	90.67%	87.83%	90.18%	88.37%	86.41%	84.09%	85.59%	84.15%
					Trend		▲	▲	▼	▲	▼	▲	▼	▲	▼	▼	▼	▲	▼
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance		86.97%	90.55%	90.55%	90.55%	89.60%	89.60%	89.60%	88.23%	88.23%	88.23%	84.55%	84.55%	84.55%
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	5	3	4	7	4.5	5.5	9.5	8.5	3	5	2	4
					Denominator		11.5	13.5	13	5	12	9.5	7	17.5	10.5	13.5	14.5	6	14
					Performance		34.78%	37.04%	23.08%	80.00%	58.33%	47.37%	78.57%	54.29%	80.95%	22.22%	34.48%	33.33%	28.57%
					Trend		▲	▲	▼	▲	▼	▼	▲	▼	▲	▼	▲	▼	▼
					Target %		85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
					Qtrly Performance		40.85%	38.10%	38.10%	38.10%	59.65%	59.65%	59.65%	50.60%	50.60%	50.60%	31.88%	31.88%	31.88%
Cancer: 62 Day Screening Referrals (Numbers)		**Owner - Divisional Manager Gynaecology**																	
KPI033	NHSI	Gynaecology	<=	5	Performance Value		1.0	2.0	0.5	2.0	2.0	1.5	2.0	0.0	4.5	0.5	2.0	2.0	1.5
					Trend		▶	▲	▼	▲	▶	▼	▲	▼	▲	▼	▲	▶	▼
					Target Value		5	5	5	5	5	5	5	5	5	5	5	5	5
					Qtrly Performance Value		9	4.5	4.5	4.5	5.5	5.5	5.5		5	5	5.5	5.5	5.5
Cancer: 62 Day Screening Referrals (Percentage)		**Owner - Divisional Manager Gynaecology**																	
KPI034	NHSI	Gynaecology	>=	90.0%	Numerator		1	1	0	2	2	1	2	0	4	0	1	1	1
					Denominator		1	2	0.5	2	2	1.5	2	0	4.5	0.5	2	2	1.5
					Performance		100.00%	50.00%	0.00%	100.00%	100.00%	66.67%	100.00%		88.89%	0.00%	50.00%	50.00%	66.67%
					Trend		▶	▼	▼	▲	▶	▼	▲			▼	▲	▶	▲
					Target %		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
					Qtrly Performance		100.00%	66.67%	66.67%	66.67%	90.91%	90.91%	90.91%	80.00%	80.00%	80.00%	54.55%	54.55%	54.55%
Cancer: 104 Day Breaches		**Owner - Divisional Manager Gynaecology**																	
KPI352	Trust Objectives	Gynaecology	=	0	Performance Value		5	2	5	0	3	4	1	0	1	3	4	1	7
					Trend		▲	▼	▲	▼	▲	▲	▼	▼	▲	▲	▲	▼	▲
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		10	7	7	7	8	8	8		4	4	12	12	12
A&E: Total Time Spent in department (95th Percentile)		**Owner - Divisional Manager Gynaecology**																	
KPI012	Trust Objectives	Gynaecology	<=	240	Performance Value		229	238	217	229	229	232	260	236	222	221	226	213	211
					Trend		▼	▲	▼	▲	▶	▲	▲	▼	▼	▼	▲	▼	▼
					Target Value		240	240	240	240	240	240	240	240	240	240	240	240	240
					Qtrly Performance Value		690	684	684	684	721	721	721	679	679	679	650	650	650

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Complaints: Number Received	**Owner - Head of Audit, Effectiveness and Patient Experience**																		
KPI038T	NHSI / Quality Strat	Trust	<=	15	Performance Value		2	8	5	7	9	7	10	6	6	7	3	10	4
					Trend		▼	▲	▼	▲	▲	▼	▲	▼	▶	▲	▼	▲	▼
					Target Value		15	15	15	15	15	15	15	15	15	15	15	15	15
					Qtrly Performance Value		11	20	20	20	26	26	26	19	19	19	17	17	17

Liverpool Women's NHS Foundation Trust

Agenda Item	2019/175

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	Finance Performance Review Month 6 2019/20
DATE OF MEETING:	Thursday, 07 November 2019
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	Claire Scott, Head of Financial Management Eva Horgan, Deputy Director of Finance
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☐ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care,* ☒

	supports learning and innovation, and promotes an open and fair culture. ***ALL DOMAINS*** ☐			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒		**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other:	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the Month 6 Financial Position.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee		
	Date of meeting	Monday, 21 October 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 6 the Trust is reporting a YTD deficit of £1.0m against a deficit budget of £1.2m, giving a year to date favourable variance of £0.2m. The key areas of financial performance are summarised below.[1]

	Plan	Actual	Variance	RAG
Surplus/(Deficit) YTD	-£1.2m	-£1.0m	£0.2m	↑
Surplus/ (Deficit) FOT	£0.0m	£0.2m	£0.2m	↔
NHSI Rating	3	3	0	↔
Cash	£4.6m	£6.2m	£1.6m	↔
Total CIP Achievement YTD	£0.6m	£0.6m	£0.0m	↔
Recurrent CIP Achievement YTD	£0.6m	£0.6m	£0.0m	↔
Capital Spend YTD	£11.8m	£8.4m	-£3.4m	↑

The Month 6 financial submission to NHSI is consistent with the contents of this report.

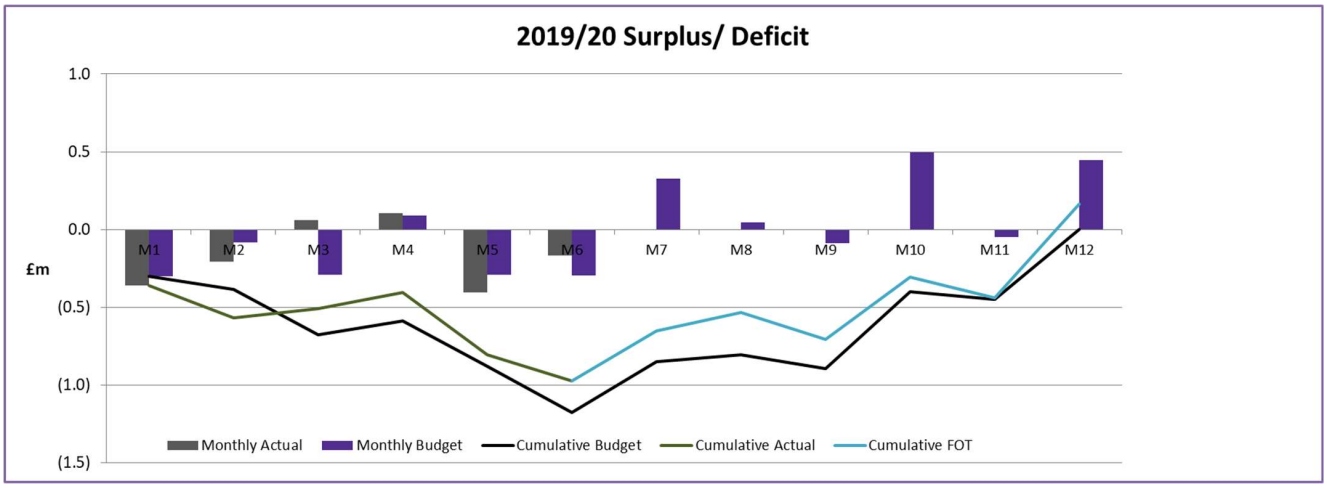
[1] NHSI Rating: Red is 4 or 5, Amber 3 and Green 2 or 1. Cash: Red is <£1m, Amber £1m-£4m and Green £4m+. Capital is not RAG rated. All other KPIs: Red is >10% off plan, Amber 0-10% off plan and Green at plan or better. Arrows denote movement from the prior month.

Liverpool Women's NHS Foundation Trust

Report

1. Summary Financial Position

At Month 6 the Trust is reporting a deficit of £1.0m against a deficit budget of £1.2m. The Trust is forecasting delivery of the breakeven control total, after £4.6m of central funding. The actual forecast is a £0.2m surplus due to receipt of PSF in 2019/20 in relation to 2018/19, but this is adjusted out in the control total calculation.



CIP is on track for Month 6, although note that the target was relatively low, with more schemes coming on line from Month 7.

The bottom up forecast that was undertaken at Month 5 provided further assurance regarding the achievement of the Trustwide control total for 2019/20. However it also highlighted that the underlying position for the Trust has further deteriorated.

2. Divisional Summary Overview

Family Health: The Family Health Divisional position is similar to Month 5. The division is within budget in month, year to date and in the forecast.

Gynaecology: The division is now £1.7m behind plan YTD and is forecasting an overspend of £2.7m in the full year.

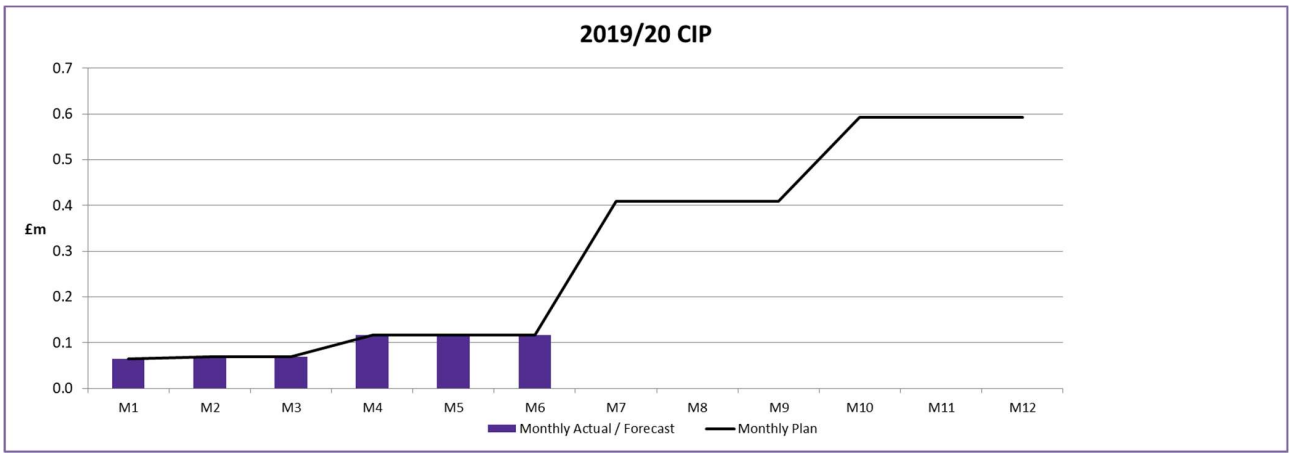
Clinical Support Services: The division is within budget in month, year to date and in the full year forecast.

Agency: Agency costs were significantly above budget at £1.1m year to date, and cannot continue at the current rate as the cap of £1.8m would be breached. Actions are in place to mitigate this.

3. CIP

Although the Trust is facing other financial challenges, the position in relation to CIP remains positive, reflective of the early, robust planning and also compensating actions taken at an early stage. Risks which have materialised were not unexpected, and have been managed through the application of grip and control measures such as a review of contracts. The result of this is that the Trust is on plan YTD and expects to deliver the required level of CIP.

The graph below shows current performance and plan.



4. Contract Performance

Income YTD is £1.6m higher than would have been received under PbR under Acting as One. This has remained the same (and not deteriorated) since Month 4 due to increased Maternity activity related to One to One Midwives going into administration.

Directorate	CCG	Month 6 Block	Month 6 Actual	Month 6 Variance	YTD Block	YTD Actual	YTD Variance	YTD % Variance	GBP(£000's) at Risk
Maternity	Liverpool	2,317	2,159	(158)	14,138	13,718	(420)	-3%	(130)
Maternity	South Sefton	527	477	(50)	3,222	3,036	(186)	-6%	(57)
Maternity	Southport & Formby	53	68	15	323	274	(49)	-15%	(15)
Maternity Total		**2,896**	**2,704**	**(192)**	**17,683**	**17,028**	**(655)**	**-4%**	**(202)**
Gynaecology	Liverpool	1,094	1,014	(81)	6,396	6,003	(393)	-6%	(121)
Gynaecology	South Sefton	303	255	(48)	1,773	1,465	(307)	-17%	(95)
Gynaecology	Southport & Formby	38	25	(13)	221	178	(43)	-20%	(13)
Gynaecology Total		**1,435**	**1,293**	**(142)**	**8,390**	**7,646**	**(744)**	**-9%**	(229)
Hewitt	Liverpool	151	93	(58)	880	716	(164)	-19%	(51)
Hewitt	South Sefton	40	27	(13)	234	181	(53)	-23%	(16)
Hewitt	Southport & Formby	23	15	(8)	134	109	(26)	-19%	(8)
Hewitt Total		**214**	**135**	**(79)**	**1,248**	**1,006**	**(242)**	**-19%**	**(75)**
Other	Liverpool	19	15	(4)	112	135	24	21%	7
Other	South Sefton	5	4	(0)	27	77	50	188%	16
Other	Southport & Formby	1	0	(1)	5	19	14	274%	4
Other Total		**25**	**20**	**(5)**	**144**	**232**	**89**	**62%**	**27**
Total		**4,570**	**4,152**	**(418)**	**27,464**	**25,912**	**(1,553)**	**-5.65%**	**(479)**

5. Forecast Out-turn

A full bottom up forecast was undertaken at Month 5 to give greater assurance regarding delivery of the Control Total and to be the basis of the final Long Term Plan submission. The forecast was signed off by each clinical division and agreed as the most likely position. In most areas the Month 6 forecast is materially similar to prior months.

6. Cash and Borrowings

At £6.2m, the cash balance is higher than planned by £1.6m, primarily due to early receipt of CCG income.

7. Capital Expenditure

Capital expenditure remains £3.5m behind plan year to date, primarily relating to medical equipment (£1.6m) and the Neonatal development (£1.0m). Both areas are expected to increase later in the year.

8. Balance Sheet

Debtors have remained fairly steady, but there are some large payments anticipated over the next few months. Considerable work has been undertaken to resolve disputes with several commitments to pay made.

The Trust has been liaising with the administrators of One to One, having been left with a final debt of £470k. NHS England and Improvement have provided assurances that local providers should not suffer any negative financial impact. It is possible some of this debt will be recovered through one of these processes, though it is unlikely to be the full amount. This benefit will not be recognised until this is certain.

A number of provisions have been released or are expected to be released within the year.

9. BAF Risk

There are no proposed changes to the BAF risk score.

10. Conclusion & Recommendation

The Board are asked to note the Month 6 financial position.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M6

YEAR ENDING 31 MARCH 2020

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M6
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	2,140	2,374	6,661	7,176
(b) PDC + Interest Payable + Loans Repaid	5,919	7,941	7,262	9,280
CSC Ratio = (a) / (b)	**0.36**	**0.30**	**0.92**	**0.77**
NHSI CSC SCORE	4	4	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	(15,096)	(14,671)	(13,172)	(13,211)
(b) Expenditure	55,995	55,950	110,554	109,632
(c) Daily Expenditure	306	306	303	300
Liquidity Ratio = (a) / (c)	**(49.3)**	**(48.0)**	**(43.5)**	**(44.0)**
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)	1,177	1,157	(4)	(7)
Total Income	(58,110)	(58,122)	(117,167)	(116,584)
I&E Margin	**-2.0%**	**-2.0%**	**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)		-2.00%		0.00%
I&E Margin (Plan)		-2.00%		0.00%
I&E Variance Margin	**0.00%**	**0.00%**	**0.00%**	**0.00%**
NHSI I&E MARGIN VARIANCE SCORE	1	1	1	1
Ratio Score 1 = 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%				
AGENCY SPEND				
YTD Providers Cap	894	894	1,792	1,792
YTD Agency Expenditure	594	1,091	1,188	1,721
	-33.6%	**22.0%**	**-33.7%**	**-4.0%**
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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M6
YEAR ENDING 31 MARCH 2020

INCOME & EXPENDITURE £'000	MONTH			YEAR TO DATE			YEAR		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	FOT	Variance
Income									
Clinical Income	(8,573)	(8,500)	(73)	(52,664)	(52,347)	(317)	(104,520)	(104,174)	(345)
Non-Clinical Income	(937)	(1,258)	321	(5,445)	(5,940)	494	(12,647)	(12,575)	(72)
Total Income	**(9,509)**	**(9,758)**	**248**	**(58,110)**	**(58,287)**	**178**	**(117,167)**	**(116,749)**	**(417)**
Expenditure									
Pay Costs	5,837	5,903	(66)	35,350	35,428	(78)	70,856	71,604	(748)
Non-Pay Costs	2,254	2,308	(54)	13,631	13,508	123	26,634	24,979	1,655
CNST	1,169	1,169	(0)	7,013	7,013	(0)	13,064	13,049	15
Total Expenditure	**9,260**	**9,381**	**(120)**	**55,995**	**55,950**	**45**	**110,554**	**109,632**	**922**
EBITDA	**(249)**	**(377)**	**128**	**(2,115)**	**(2,337)**	**222**	**(6,613)**	**(7,118)**	**505**
Technical Items									
Depreciation	380	377	3	2,334	2,385	(51)	4,641	4,743	(102)
Interest Payable	36	24	12	175	142	33	402	333	69
Interest Receivable	(4)	(4)	0	(25)	(36)	11	(48)	(58)	10
PDC Dividend	135	143	(8)	809	843	(34)	1,617	1,685	(68)
Profit / Loss on Disposal	0	0	0	0	0	0	0	250	(250)
Total Technical Items	**546**	**540**	**7**	**3,292**	**3,333**	**(41)**	**6,613**	**6,953**	**(340)**
(Surplus) / Deficit	**297**	**162**	**135**	**1,177**	**995**	**182**	**0**	**(165)**	**165**
Control Total Adjustments									
18/19 Additional PSF					*165*	*(165)*		*165*	*(165)*
Remove capital donations/grants I&E impact					*-2*	*2*	*-4*	*-7*	*3*
Adjusted Control Total	***297***	***162***	***135***	***1,177***	***1,158***	***19***	***(4)***	***(7)***	***3***

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M6
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	379	349	30	2,286	1,878	409	4,558	4,033	525
Medical	1,461	1,577	(116)	8,660	8,775	(115)	17,682	18,075	(393)
Nursing & Midwifery	2,561	2,615	(53)	15,131	15,469	(337)	30,719	31,666	(946)
Healthcare Assistants	452	432	19	2,683	2,492	190	5,393	4,915	478
Other Clinical	348	274	74	2,755	2,664	91	4,842	4,866	(24)
Admin Support	178	157	21	1,067	959	109	2,140	2,006	134
Corporate Services	360	373	(12)	2,178	2,101	77	4,340	4,323	17
Agency & Locum	98	127	(28)	590	1,091	(501)	1,180	1,721	(541)
Total Pay Costs	**5,837**	**5,903**	**(66)**	**35,350**	**35,428**	**(78)**	**70,856**	**71,604**	**(748)**
Non Pay Costs									
Clinical Suppplies	652	680	(28)	3,999	4,160	(161)	7,859	7,991	(132)
Non-Clinical Supplies	509	537	(27)	3,056	2,926	130	6,116	5,832	285
CNST	1,169	1,169	(0)	7,013	7,013	(0)	13,064	13,049	15
Premises & IT Costs	485	562	(77)	2,926	3,060	(135)	5,931	6,172	(240)
Service Contracts	608	529	79	3,651	3,362	289	6,727	4,984	1,743
Total Non-Pay Costs	**3,423**	**3,477**	**(54)**	**20,645**	**20,521**	**123**	**39,698**	**38,028**	**1,670**
Total Expenditure	**9,260**	**9,381**	**(120)**	**55,995**	**55,950**	**45**	**110,554**	**109,632**	**922**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M6
YEAR ENDING 31 MARCH 2020

INCOME & EXPENDITURE	MONTH			YEAR TO DATE			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	FOT	Variance
Maternity									
Income	(3,685)	(3,778)	93	(22,437)	(22,669)	232	(44,885)	(45,427)	543
Expenditure	1,852	1,895	(43)	11,004	11,186	(182)	22,172	22,459	(286)
Total Maternity	**(1,833)**	**(1,883)**	**50**	**(11,433)**	**(11,483)**	**50**	**(22,713)**	**(22,969)**	**256**
Neonatal									
Income	(1,404)	(1,425)	22	(8,547)	(8,441)	(105)	(17,072)	(17,343)	271
Expenditure	1,100	1,062	38	6,559	6,347	212	13,158	12,814	345
Total Neonatal	**(304)**	**(364)**	**60**	**(1,987)**	**(2,094)**	**107**	**(3,914)**	**(4,530)**	**616**
Division of Family Health - Total	**(2,137)**	**(2,247)**	**110**	**(13,421)**	**(13,577)**	**156**	**(26,626)**	**(27,499)**	**872**
Gynaecology									
Income	(2,382)	(2,252)	(131)	(13,892)	(12,977)	(915)	(27,996)	(26,680)	(1,316)
Expenditure	934	1,081	(147)	5,542	5,938	(396)	11,444	11,977	(533)
Total Gynaecology	**(1,449)**	**(1,170)**	**(278)**	**(8,350)**	**(7,039)**	**(1,311)**	**(16,552)**	**(14,702)**	**(1,849)**
Hewitt Centre									
Income	(868)	(828)	(40)	(5,375)	(5,237)	(138)	(11,001)	(10,613)	(388)
Expenditure	684	672	12	4,076	4,295	(220)	8,130	8,588	(458)
Total Hewitt Centre	**(184)**	**(156)**	**(28)**	**(1,300)**	**(942)**	**(358)**	**(2,871)**	**(2,025)**	**(846)**
Division of Gynaecology - Total	**(1,633)**	**(1,326)**	**(306)**	**(9,649)**	**(7,981)**	**(1,669)**	**(19,423)**	**(16,727)**	**(2,696)**
Theatres									
Income	(39)	(39)	(0)	(236)	(248)	11	(472)	(488)	15
Expenditure	702	741	(39)	4,200	4,153	46	8,411	8,679	(268)
Total Theatres	**662**	**701**	**(39)**	**3,963**	**3,906**	**58**	**7,938**	**8,191**	**(253)**
Genetics									
Income	(311)	(386)	74	(2,797)	(3,214)	417	(4,640)	(5,296)	656
Expenditure	187	150	37	1,857	2,166	(309)	2,979	3,528	(549)
Total Genetics	**(125)**	**(236)**	**111**	**(940)**	**(1,049)**	**108**	**(1,661)**	**(1,768)**	**107**
Other Clinical Support									
Income	(30)	(27)	(3)	(178)	(156)	(22)	(357)	(308)	(49)
Expenditure	677	557	120	4,055	3,725	329	8,121	7,697	424
Total Clinical Support	**647**	**529**	**117**	**3,877**	**3,569**	**308**	**7,764**	**7,389**	**375**
Division of Clinical Support - Total	**1,185**	**995**	**190**	**6,900**	**6,427**	**474**	**14,041**	**13,812**	**229**
Corporate & Trust Technical Items									
Income	(790)	(1,023)	233	(4,648)	(5,345)	697	(10,743)	(10,594)	(149)
Expenditure	3,672	3,763	(92)	21,995	21,472	523	42,752	40,843	1,908
Total Corporate	**2,882**	**2,741**	**141**	**17,347**	**16,127**	**1,220**	**32,008**	**30,249**	**1,759**
(Surplus) / Deficit	**297**	**162**	**135**	**1,177**	**995**	**182**	**0**	**(165)**	**165**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
CIP: M6
YEAR ENDING 31 MARCH 2020

NHSI SCHEME REFERENCE	SCHEME NAME	ACCOUNTING	RISK RATING	MONTH 6			YTD			YEAR			FYE		
				TARGET	ACTUAL	VARIANCE	TARGET	ACTUAL	VARIANCE	TARGET	FOT	VARIANCE	TARGET	FOT	VARIANCE
Trust scheme 1	Car Parking Consumable	Non-Pay	Medium	1	1	0	6	6	0	12	12	0	12	12	0
Trust scheme 2	CNST Maternity Incentiv	Non-Pay	Medium	0	0	0	0	0	0	960	960	0	960	960	0
Trust scheme 3	Estates Income Generati	Income	Low	3	3	0	18	18	0	36	36	0	36	36	0
Trust scheme 4	Contract Savings	Pay	Low	14	14	0	84	84	0	168	168	0	168	168	0
Trust scheme 5	Coding & Counting	Income	Low	13	13	0	78	78	0	156	156	0	156	156	0
Trust scheme 6	Decontamination Contra	Non-Pay	Low	3	3	0	18	18	0	36	36	0	36	36	0
Trust scheme 7	Meeting Utilisation	Income	Low	1	1	0	5	4	(1)	11	10	(1)	11	12	1
Trust scheme 8/9	HFEA Tender	Income/Pay	Medium	2	2	0	12	12	0	24	24	0	24	24	0
Trust scheme 10	HTE Contract Fees	Non-Pay	Low	3	3	0	18	18	0	36	36	0	36	36	0
Trust scheme 11	Imaging Income Opportu	Income	Low	2	2	0	12	12	(0)	24	24	0	24	24	0
Trust scheme 12	Midwifery Productivity	Pay	Medium	23	23	0	90	90	0	228	228	0	228	228	0
Trust scheme 13	Pharmacy Review	Non-Pay	Medium	31	13	(18)	93	37	(56)	279	180	(99)	279	311	32
Trust scheme 14	Private Patient Fees	Income	Low	0	0	0	0	0	0	198	198	0	198	198	0
Trust scheme 15	Procurement (various)	Non-Pay	Medium	0	0	0	0	0	0	570	570	0	570	570	0
Trust scheme 16	Rateable Value Review	Non-Pay	Medium	0	0	0	0	0	0	30	0	(30)	30	0	(30)
Trust scheme 17	CQC Fees	Non-Pay	Low	7	7	0	42	42	0	84	84	0	84	84	0
Trust scheme 18	Restructuring	Pay	Low	7	7	0	42	42	0	84	84	0	84	84	0
Trust scheme 19	Section 106	Income	High	0	0	0	0	0	0	501	0	(501)	501	75	(426)
Trust scheme 20	Job Planning	Pay	Medium	4	4	0	20	20	0	44	44	0	44	48	4
Trust scheme 21	Sperm Bank	Non-Pay	High	0	0	0	0	0	0	51	51	0	51	204	153
Trust scheme 22	Sutures	Non-Pay	Low	2	2	0	12	12	0	24	24	0	24	24	0
Non-recurrent Mitiga	Gynaecology	Non-Pay	Low	0	0	0	0	1	1	0	1	1	0	0	0
Recurrent Mitigation	Genetics Overheads	Income	Low	0	0	0	0	0	0	0	137	137	0	137	137
Recurrent Mitigation	Contracts Review	Non-Pay	Low	0	18	18	0	56	56	0	392	392	0	100	100
Non-recurrent Mitiga	IT Contracts Review	Non-Pay	High	0	0	0	0	0	0	0	101	101	0	0	0
TOTAL				**116**	**116**	**0**	**550**	**550**	**0**	**3,556**	**3,556**	**0**	**3,556**	**3,527**	**(29)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BALANCE SHEET: M6
YEAR ENDING 31 MARCH 2020

BALANCE SHEET £'000	YEAR TO DATE Opening	M06 Actual	Movement
Non Current Assets	**79,968**	**85,945**	5,977
Current Assets			
Cash	9,066	6,243	(2,823)
Debtors	7,273	6,709	(564)
Inventories	489	474	(15)
Total Current Assets	**16,828**	**13,426**	**(3,402)**
Liabilities			
Creditors due < 1 year	(17,436)	(23,252)	(5,816)
Creditors due > 1 year	(1,654)	(1,639)	15
Loans	(13,635)	(11,957)	1,678
Provisions	(4,631)	(4,078)	553
Total Liabilities	**(37,356)**	**(40,926)**	(3,570)
TOTAL ASSETS EMPLOYED	**59,440**	**58,445**	**(995)**
Taxpayers Equity			
PDC	40,088	40,088	0
Revaluation Reserve	14,503	14,503	0
Retained Earnings	4,849	3,854	(995)
TOTAL TAXPAYERS EQUITY	**59,440**	**58,445**	**(995)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
CASHFLOW STATEMENT: M6
YEAR ENDING 31 MARCH 2020

CASHFLOW STATEMENT	YEAR TO DATE		
£'000	Budget	Actual	Variance
Cash flows from operating activities	(221)	(46)	(175)
Depreciation and amortisation	2,334	2,384	(50)
Movement in working capital	1,922	5,691	(3,769)
Net cash generated from / (used in) operations	**4,035**	**8,029**	**(3,994)**
Interest received	26	36	(10)
Purchase of property, plant and equipment and intangible assets	(11,807)	(8,251)	(3,556)
Proceeds from sales of property, plant and equipment and intangible assets	721	0	721
Net cash generated from/(used in) investing activities	**(11,060)**	**(8,215)**	**(2,845)**
PDC Capital Programme Funding - received	612	0	612
Loans from Department of Health Capital - received	7,851	5,278	2,573
Loans from Department of Health Capital - repaid	(306)	(306)	0
Loans from Department of Health Revenue - received	0	0	0
Loans from Department of Health Revenue - repaid	(4,630)	(6,650)	2,020
Interest paid	(96)	(137)	41
PDC dividend (paid)/refunded	(806)	(822)	16
Net cash generated from/(used in) financing activities	**2,625**	**(2,637)**	**5,262**
Increase/(decrease) in cash and cash equivalents	**(4,400)**	**(2,823)**	**(1,577)**
Cash and cash equivalents at start of period	9,000	9,066	(66)
Cash and cash equivalents at end of period	**4,600**	**6,243**	**(1,643)**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding at M6
Loans from Department of Health Capital (ITFF) - 2.0% Interest Rate	5,500	(2,446)	3,054
Loans from Department of Health Capital (Neonatal) - 2.54% Interest Rate	8,903	0	8,903
Loans from Department of Health Revenue - 1.50% Interest Rate	14,612	(14,612)	0
Total	**29,015**	**(17,058)**	**11,957**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M6
YEAR ENDING 31 MARCH 2020

CAPITAL EXPENDITURE	Year to Date			Full Year		
£'000	Budget	Actual	Variance	Plan	Forecast	Variance
Neonatal New Building	7,851	6,854	997	10,410	10,410	0
Estates Schemes	480	147	333	960	785	175
Global Digital Examplar Fast Follower Project	588	528	60	1,225	2,400	(1,175)
Medical Equipment	1,966	401	1,565	2,177	2,478	(301)
IT Schemes	928	460	468	1,479	1,496	(17)
Total	**11,813**	**8,390**	**3,423**	**16,251**	**17,569**	**(1,318)**

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.

Liverpool Women's NHS Foundation Trust

Agenda Item	2019/176

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Nursing, Midwifery and Allied Health Professions Strategy**
DATE OF MEETING:	Thursday, 07 November 2019
ACTION REQUIRED	**Approve**
EXECUTIVE DIRECTOR:	Caron Lappin, Director of Nursing and Midwifery
AUTHOR(S):	Janet Brennan, Deputy Director of Nursing and Midwifery
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *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. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☐ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE****- People are protected from abuse and harm* ☐ ***EFFECTIVE*** *- people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING*** *- the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE*** *– the services meet people's needs.* ☐ ***WELL-LED*** *- the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care,* ☐

	supports learning and innovation, and promotes an open and fair culture. ***ALL DOMAINS*** ☒	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☐	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: Click here to enter text.
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***For approval***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Putting People First Committee Or type here if not on list: *Click here to enter text.*
	Date of meeting	Monday, 23 September 2019

Executive Summary

The Nursing, Midwifery and AHP Strategy is a five- year plan to provide a framework aligned with the vision, aims and values of Liverpool Women's Hospital Foundation Trust. The overarching aim of the strategy is to enable Nurses, Midwives and AHP's to provide the best quality of care to all women, babies, patients, families and carers. The strategy is flexible and responsive to meet the needs of our population and the Nursing, Midwifery and AHP workforce with measurable outcomes to monitor success.

The NHS is going through challenging times and this strategy will support and give clear direction and focus to the Nursing, Midwifery and AHP teams, building on the already excellent care that is developed daily. Following extensive engagement across the Trust, external stakeholders, women, patients and families 6 key areas of focus have been developed.

WECARE
W- Workforce
E- Experience
C- Compassionate Communication
A- Ambition
R- Research
E- Excellence

The Strategy will have annual deliverables monitored through the Nursing and Midwifery Professional forum and the PPF Committee which reports to the Board.

Liverpool Women's NHS Foundation Trust

Report

Introduction

Over the last 7 months we have developed the strategy through engagement with staff across all the trust, women, patients and carers and external stakeholders. This strategy has also been developed alongside existing strategies which include; *Quality Strategy, putting patients first strategy, Research and Innovation strategy, Patient experience strategy and Putting the safe into safeguarding strategy.* The wider strategic vision has also been considered: *Future generations and Fair and Just Culture.* The development of the strategy has also included consultation and recommendations from the Equality, Diversity and Inclusion lead.

Next Steps

Once the strategy (Appendix 1) has been approved an implementation 5-year plan (Appendix 2) will be delivered with annual plan on a page (Appendix 3). Each division will provide action plans on how they will deliver the strategy. An away day is planned for all the senior nursing, midwifery and AHP team to support developing their action plans. The strategy will be launched in January 2020 as part of LWH 25-year celebrations and the year of the Nurse and the Midwife. Planning is in place as to how the strategy will be launched. Comms are supporting with graphics and producing an infographic for the annual plan on a page.

Conclusion/Recommendation

The Trust Board is asked to approve the strategy and the next steps.

Appendix 1

Liverpool Women's NHS Foundation Trust

Nursing, Midwifery and AHP Strategy 2020-2025

WECARE

" To be a competent, effective and professional workforce proud to deliver safe, personalised care to meet the needs of our women, babies, families and carers "

The Nursing, Midwifery and AHP Strategy is a five- year plan to provide a framework aligned with the vision, aims and values of Liverpool Women's Hospital Foundation Trust. The overarching aim of the strategy is to enable Nurses, Midwives and AHP's and support workers to provide the best quality of care to all women, babies, patients, families and carers. The strategy is flexible and responsive to meet the needs of our population and the Nursing, Midwifery and AHP workforce with measurable outcomes to monitor success. We Delivered 8,379 babies in 2018 – an average of 23 babies born at Liverpool Women's every day. In 2018 we undertook gynaecological inpatient procedures on 4,876 women in and 30,611 gynaecological outpatient procedures. We cared for 1,013 babies in our neonatal intensive and high dependency care units. We performed 1,294 cycles of in vitro fertilisation (IVF).

The NHS is going through challenging times and this strategy supports and gives clear direction and focus to the Nursing, Midwifery and AHP teams, building on the already excellent care that is delivered daily. Following extensive engagement across the Trust, external stakeholders, women, patients and families.

Every Nurse, Midwife, AHP and support worker is valued and has a part to play in ensuring the delivery of high quality safe and effective care. The strategy will generate local plans from each of the divisions and corporate services. 6 key themes have been identified to form the strategy.

W- Workforce
E- Experience
C- Compassionate Communication
A- Ambition
R- Research
E- Excellence

WECARE

Workforce

We have > 900 nurses, midwives and AHP staff working across LWH.

There are recruitment and retention challenges across the NHS nationally and locally. LWH has an ageing N&M workforce with more than 32% over 50 years of age. There are some areas of our N&M workforce with a high turnover rate, however, LWH turnover rate remains below the national average.

Sickness is high in some areas mainly relating to stress and anxiety. Staff survey scores are low in comparison to other Trusts as recommending LWH as a place to work. Our ambition is to create a place of work where everybody feels welcomed and their contribution recognised. We will engage, listen, respond, value and develop our Nursing, Midwifery AHP and support staff workforce for the future to ensure LWH is a place they wish to work whilst ensuring efficient use of staff resources and value for money. We will develop an engagement plan

and commit to developing and strengthening the workforce recognising their health and wellbeing and celebrating success.

Experience

The promotion and achievement of a positive experience is of paramount importance. It is the right thing to do for our women, babies' families and carers and is central to building and strengthening the Trust's reputation and increasing public confidence. It is what we would expect for our families and friends and a positive experience is linked to more positive clinical outcomes.

Women, babies' families and carers experience will be at the heart of everything we do. We will listen to what they are saying and each nurse, midwife, AHP and support worker will put their patients first and recognise that a positive patient experience is part of everyone's responsibility. We will learn from incidents and complaints. We will proactively seek and act upon a range of feedback to evaluate the impact of the patients experience and We will commit to ensuring the environment is important for our patients and staff.

Compassionate Communication

Care and compassion are fundamental to the care we deliver. So, it is important that we strive to get this right. Some of our top themes from complaints and incidents are relating to communication so this must be one of our top priorities.

We will focus on positive, kind and caring communication with our women, patients, families, carers and staff. We will develop a more positive culture which in turn will improve patient and staff experience.

Ambition

Having the right people with the right skills to deliver services is imperative if we are to achieve the best for our women, babies and family's carers and students. We want to be the best we can be. We are the largest hospital in Europe to exclusively care for the health needs of women and will demonstrate the amazing innovations we undertake to provide excellent care for our women, babies families and carers.

We will commit to developing an innovative, competent, able workforce who will provide the best women, babies and families focused care. We aim to be an outstanding learning environment for not only our students but all our workforce who demonstrate the competencies required to deliver care for our women, babies and patients.

Research

Healthcare institutions that embrace research demonstrates better clinical outcomes. The trusts vision is to foster an evidence based and research culture and it is important that Nurses, Midwives sand AHP's are part of this culture.

We will raise the profile of Nursing, Midwifery and AHP research and Nursing and Midwifery research teams will be included in all aspects of the strategy. We will increase the number of nurses, midwives and AHP's involved in research and audit activity. Nurses Midwives and AHPs will utilise practice development, research, audit and benchmarking to integrate evidence-based care into their practice and will contribute to the development of that evidence to improve outcomes for women, babies and patients.

Excellence

Measuring the care, we deliver is key to making improvements. Care can always be improved, and it is vital that we show evidence of improvement when needed. Safety of our women, babies, patients and families is paramount. We will recognise, report, empower and protect and monitor our performance. Quality improvement plays a crucial role in improving practice safely, effectively and efficiently and fostering a culture of innovation.

We will be a strong, credible, innovative and professional workforce who are accountable and provide safe quality care for our Women, babies, patients, families and carers. Nurses, midwives, AHP's and support staff will take ownership for quality care, holding themselves and others to account for the highest standards of care, acting to escalate concerns and address poor standards.

Each year we will develop actions to deliver the strategy so each nurse, midwife, AHP and support worker can identify what their contributions are.

Liverpool Women's NHS Foundation Trust

Nursing, Midwifery and AHP Strategy 2020-2025

WECARE

" To be a competent, effective and professional workforce proud to deliver safe, personalised care to meet the needs of our women, babies, families and carers "

Appendix 2

Contents

Message from Chief Executive

Introduction from the Director of Nursing & Midwifery

Summary

The Nursing, Midwifery and AHP Strategy is a five- year plan to provide a framework aligned with the vision, aims and values of Liverpool Women's Hospital Foundation Trust. The overarching aim of the strategy is to enable Nurses, Midwives and AHP's to provide the best quality of care to all women, babies, patients, families and carers. The strategy is flexible and responsive to meet the needs of our population and the Nursing, Midwifery and AHP workforce with measurable outcomes to monitor success.

The NHS is going through challenging times and this strategy will support and give clear direction and focus to the Nursing, Midwifery and AHP teams, building on the already excellent care that is developed daily. Following extensive engagement across the Trust, external stakeholders, women, patients and families 6 key areas of focus have been developed.

WECARE

W- Workforce

E- Experience

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A- Ambition

R- Research

E- Excellence

The Strategy will have annual deliverables monitored through the Nursing and Midwifery Professional forum and the PPF Committee which reports to the Board.

National Context

The Strategy has incorporated the NHS plan which sets out to expand the number of Nurses and other undergraduate places as one of its many objectives. The interim people plan focuses on making the NHS the best place to work, improving leadership culture , addressing urgent workforce shortages in Nursing , delivering 21st century care and develop a new operating model for workforce. When the full 5 year people plan is developed the Strategy will be responsive to that plan.

Ruth May, Chief Nursing Officer

The CNO has set out key priorities for Nursing in 2019/2020

Workforce

- 1 in 10 nurses are leaving the profession each year. 45,000 nurse vacancies in England
- Recruitment programme – increasing student placements and an investment in £42 million
- Exploring new models e.g. Nursing associates and creating a pathway to become a trained nurse
- Supportive placements to help the health and well-being of staff
- Strong leadership development at all levels, talent pipeline support for all nurses and midwives
- Take action against inequality

Reputation

- The reputation of Nursing and Midwifery values, building a workforce fit for the future, if others need to value us we need to first value ourselves

Contribution

- A contribution to the long-term plan speaking with one powerful collective voice to influence, lead and drive change.

Jaqueline Dunkerley-Bent, Chief Midwifery Officer

The CMO has set out key priorities for Midwifery for 2019/2020

- **Introduction and implementation of AQUIP for midwives** (Advocating for Education and Quality Improvement), including the operational delivery of the PMA (Professional Midwifery Advocate) modal for midwives.
- **Promote safer births as part of the NHS 10-year plan**, including the national roll out of continuity of care modals for midwifery. Increased digital care within maternity services and improve Brest feeding rates nationally.
- **Workforce Developments**, increased pre- registration midwifery places across the HEE network, including the short course for midwifery for registrants already on the NMC register. Introduction of Midwifery apprenticeships in an aim to address midwifery shortfalls in staffing.

Developing the Strategy

Over the last 7 months we have developed the strategy through engagement with staff across all the trust, women, patients and carers and external stakeholders. This strategy has also been developed alongside existing strategies which include; *Quality Strategy, Putting patients first strategy, Research and Innovation strategy, Patient experience strategy and Putting the safe into safeguarding strategy.* The wider strategic vision has also been considered: *Future generations and Fair and Just Culture.*

Our Vision

"To be a competent, effective and professional workforce proud to deliver safe, personalised care to meet the needs of our Women, babies, families and carers. "

W- Workforce

What do we want to achieve?

We will engage, listen, respond, value and develop our Nursing, Midwifery and AHP workforce for the future to ensure LWH is a place they wish to work.

Why is this important?

There are recruitment and retention challenges across the NHS. LWH has an ageing N&M workforce with more than 32% over 50 years of age. There are some areas of our N&M workforce with a high turnover rate.

Sickness is high in some areas relating to stress and anxiety. Staff survey scores are low in comparison to other Trusts as recommending LWH as a place to work. Our ambition is to create a place of work where everybody feels welcomed and their contribution recognised *(Putting people first strategy- LWH 2019-2024)*

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will develop an engagement plan	• Monthly DONM engagement events/ walk rounds	✓	✓	✓	✓	✓
	• Bi- Monthly DONM briefings	✓	✓	✓	✓	✓
	• Bi-Monthly Non- Exec and senior nurse/ Midwife walk rounds	✓	✓	✓	✓	✓
	• Quarterly Divisional Head of Nursing/ Midwifery engagement events	✓	✓	✓	✓	✓

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will develop an engagement plan continued	• Posters of senior N&M team visible around the trust	✓	✓	✓	✓	✓
	• Collaborate and link with external stakeholders, e.g. CCG, CQC, external audit , Liverpool partnership	✓	✓	✓	✓	✓
How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will commit to developing and Strengthening the workforce and increasing the diversity	• Introduce the Trainee Nursing Associate role	✓	✓	✓		
	• Increase student placement	✓	✓			
	• Introduce Cadet health and social care students on placement from Southport college	✓	✓	✓	✓	✓
	• Introduce more Advanced Clinical Practice roles	✓	✓	✓		
	• Prepare and train workforce for NMC proficiency standards for students	✓				
	• Deliver the Professional Advocacy Model in Midwifery	✓	✓	✓	✓	✓
	• Develop a Band 6 Leadership programme		✓			
	• Develop a band 7 programme			✓		
	• Develop competency frameworks for all Bands	✓	✓	✓		
	• Introduce Midwifery apprenticeships	✓	✓	✓		
	• With HR- develop talent management and succession planning for workforce- Numbers of N, M & AHP staff on/ have been through talent management programme	✓	✓	✓	✓	✓

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will commit to developing and Strengthening the workforce and increasing diversity continued	• Matron Development programme	✓				
	• Deliver the retention action plan – reduction in turnover of N&M staff	✓	✓	✓	✓	
	• Introduce Making every contact count for staff	✓	✓	✓	✓	
	• All new starter HCSW will complete the care certificate	✓	✓	✓		
	• All existing HCSW will complete the care certificate		✓	✓		
	• All ward managers to be supernumerary 2 days per working week	✓	✓	✓	✓	✓
	• Ensure Consultant Nurses have an annual job plan review	✓	✓	✓	✓	✓
	• Implement job planning process for all specialist/ Non-ward-based nurses/ midwives/ AHPs		✓	✓	✓	✓
	• Review student nurse evaluations at NPF	✓	✓	✓	✓	✓
	• Engagement events with students by DONM/ DDONM and heads of Nursing/ Midwifery	✓	✓	✓	✓	✓
	• Participate and deliver outputs from the C&M workforce workstreams	✓				
	• Develop closer working relationships with internal stakeholders e.g. L&D, HR, Finance	✓	✓	✓	✓	✓
	• We will work with HR in developing talent management programmes for staff	✓	✓	✓	✓	✓

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will commit to developing and strengthening the workforce and increase the diversity continued	• We will work with HR in delivering the PPF strategy	✓	✓	✓	✓	✓
	• We will develop succession planning	✓	✓	✓	✓	✓
	• We will with HR develop a plan to increase the diversity of our workforce	✓	✓	✓	✓	✓
How will we achieve this?	**KPI's/ Measurement of success**	**2020**	**2021**	**2022**	**2023**	**2024**
We will recognise the Health and Well-being of staff	• Bi- Annual N, M & AHP listening events held by senior Nursing and midwifery leadership team	✓	✓	✓	✓	✓
	• Introduce Making every contact count for staff	✓	✓	✓	✓	✓
	• Ensure adequate healthy food provision in and out of hours	✓	✓	✓	✓	✓
	• Work with chaplaincy to provide pastoral/ spiritual support for staff	✓	✓	✓	✓	✓
	• We will ensure staff have access to coaching and mentoring	✓	✓	✓	✓	✓
	• We will access resilience training for staff	✓	✓	✓	✓	✓
	• We will ensure access to MH first aiders	✓	✓	✓	✓	✓
How will we achieve this?	**KPI's/ Measurement of success**	**2020**	**2021**	**2022**	**2023**	**2024**
We will Celebrate success	• Annual celebration of International Nurse/ Midwife & ODP day	✓	✓	✓	✓	✓
	• Nominate individuals/ teams for external awards	✓	✓	✓	✓	✓
	• Nominate individuals/ teams for internal awards	✓	✓	✓	✓	✓

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will celebrate success continued	• Celebrate monthly the year of the Nurse/ Midwife 2020	✓				
How will we achieve this	**KPI's/ Measurement of success**	**2020**	**2021**	**2022**	**2023**	**2024**
We will ensure the efficient use of staff resources and value for money	• Implement NHSP for Nursing and Midwifery and robust governance processes for Bank and Agency and overtime	✓	✓	✓	✓	✓
	• Introduce monthly monitoring of NHSP usage	✓	✓	✓	✓	✓
	• Each Division to undertake monthly e-rostering challenge meetings	✓	✓	✓	✓	✓
	• Implement E- rostering across the AHP workforce	✓	✓			
	• Annual workforce budget reviews to be signed off by DONM	✓	✓	✓	✓	✓
	• Development of specific Nursing and Midwifery performance metrics	✓	✓	✓	✓	✓
	• We will work with finance on cost improvement projects and ensure EIA are undertaken	✓	✓	✓	✓	✓
	• Ward managers will work with procurement to deliver best value for money	✓	✓	✓	✓	✓

E- Experience

What we want to achieve

Women, baby and patient experience will be at the heart of everything we do.

Why is this important?

The promotion and achievement of a positive experience is of paramount importance. It is the right thing to do for our women, babies and families and is central to building and strengthening the Trust's reputation and increasing public confidence. It is what we would expect for our families and friends and a positive experience is linked to more positive clinical outcomes *(Patient experience strategy -LWH-2018-2021)*

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will act on patient feedback	• Actions from Picker surveys will be completed within the agreed timeframes and themes identified from previous surveys	✓	✓	✓	✓	✓
	• Increase in response rate of Friends and family	✓	✓	✓	✓	✓
	• We will publish our friends and family feedback in each area.	✓	✓	✓	✓	✓
	• We will in collaboration with patient experience team report at Divisional governance themes from care opinion, complaints, Pals and Pals plus	✓	✓	✓	✓	✓
	• Reduce the number of nursing and midwifery formal complaint by 10%	✓	✓	✓	✓	✓
	• We will introduce "you said, we did "in all areas		✓	✓	✓	✓
	• We will introduce patient focused rounding in all areas	✓	✓	✓	✓	✓
	• We will introduce a patient story at NMPF	✓	✓	✓	✓	✓
	• Develop Maternity voices partnership reflecting the diversity of the women using the services	✓	✓	✓	✓	✓
	• Introduce patient reps as normal practice	✓	✓	✓	✓	✓
	• Increase Continuity of carer in Maternity	✓	✓	✓	✓	✓

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will act on patient feedback continued	• Increase involvement from patient support groups and networks and involve patient in initiatives	✓	✓	✓	✓	✓
	• We will survey patients on food provision as part of the matrons walk rounds		✓			
	• We will develop a Dignity in care policy	✓				

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will commit to ensuring the environment is important for our patients and staff	• Introduce Matron shine rounds in all areas	✓	✓	✓	✓	✓
	• Develop a Matrons operational group which reports to NMPF- with specific KPI's	✓	✓	✓	✓	✓
	• Introduce a Matron champion for the environment	✓				
	• We will display cleanliness monitoring scores for patients to see	✓	✓	✓	✓	✓
	• Relaunch the dress code policy and tackle non-adherence	✓	✓	✓	✓	✓
	• Review all uniforms		✓	✓	✓	✓
	• We will contribute to PLACE inspections	✓	✓	✓	✓	✓
	• We will undertake access audits with patients from a range of protected groups	✓	✓	✓	✓	✓

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will commit to ensuring the environment is important for our patients and staff continued	• Develop E&D champions within the divisions to raise the profile and ensure patient focused actions are completed	✓	✓	✓	✓	✓
	• We will ensure senior Nursing/ Midwifery representation in any service developments that impact on the environment of care including EPR systems.	✓	✓	✓	✓	✓
	• We will display infection prevention audit scores	✓	✓	✓	✓	✓
	• We will offer programmes for our women, patients , carers and families as part of the One Liverpool strategy 2018-2021	✓	✓	✓	✓	✓
	• We will support LWH in the future generations strategy by ensuring any risks are mitigated and actions are in place .	✓	✓	✓	✓	✓
	• We will undertake an audit of delays in transfers of our patients	✓				

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will demonstrate learning from incidents and complaints	• Develop a 7-minute briefing for staff to assist with learning from incidents/ complaints	✓	✓	✓	✓	✓
	• Each area will produce a lesson of the week at each huddle	✓	✓	✓	✓	✓

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will demonstrate learning from incidents and complaints continued	• Each division will share learning evidenced at NMPF quarterly	✓	✓	✓	✓	✓
	• We will monitor themes from PALS and PALS + and improve on any themes	✓	✓	✓	✓	✓
	• Each member of staff will know about recent complaints and Serious incidents in their areas and the actions	✓	✓	✓	✓	✓

C- Compassionate Communication

What we want to achieve

We will focus on positive, kind and caring communication with our women, patients, families, carers and staff.

Why is this important?

Care and compassion are fundamental to the care we deliver. So, it is important that we strive to get this right.

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will aim for a more positive culture	• We will develop expectations of effective communication based on the trust values	✓	✓	✓	✓	✓
	• We will roll out SAGE & THYME with the expectation of N, M&AHP staff to attend the training	✓	✓	✓	✓	✓
	• We will follow the fair and just culture strategy	✓	✓	✓	✓	✓
	• We will ensure the strategy is included in all appraisals		✓	✓	✓	✓
	• We will develop set objectives for staff	✓	✓	✓	✓	✓
	• We will praise, and reward can do attitude and positivity	✓	✓	✓	✓	✓

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will aim for a more positive culture continued	• We will discourage negativity through a fair and just culture	✓	✓	✓	✓	✓
	• We will celebrate success	✓	✓	✓	✓	✓
	• We will ensure staff are up to date with future generations strategy	✓	✓	✓	✓	✓
How will we achieve this?	**KPI's/ Measurement of success**	**2020**	**2021**	**2022**	**2023**	**2024**
We will standardise our communication	• We will develop standardised ward/ department meeting agenda and how often	✓	✓	✓	✓	✓
	• We will develop a standardised safety huddle	✓	✓	✓	✓	✓
How will we achieve this?	**KPI's/ Measurement of success**	**2020**	**2021**	**2022**	**2023**	**2024**
Patient communication	• We will develop MECC champions and roll out MECC in a phased approach by 2021	✓	✓	✓	✓	✓
	• We will be responsive to our in-patient survey results	✓	✓	✓	✓	✓
	• We will be responsive to friends and family results	✓	✓	✓	✓	✓
	• We will ensure we meet additional communication needs by compliance with AIS	✓	✓	✓	✓	✓
	• We will encourage our patients, and families to express the need for spiritual or religious support and include the hospital pastoral team.	✓	✓	✓	✓	✓
	• We will improve our complaint response rate year on year	✓	✓	✓	✓	✓
	• We will standardise information for patients boards in clinical areas	✓	✓	✓	✓	✓

A – Ambition

What we want to achieve

We will commit to developing an innovative, competent, able workforce who will provide the best women, babies families and patient focused care

Why is this important?

Having the right people with the right skills to deliver services is imperative if we are to achieve the best for our women, babies and families and students. We want to be the best we can be.

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will aim for an outstanding learning environment	• We will work with HEI to ensure a quality learning environment and achieve >90 % positive feedback from students in all areas	✓	✓	✓	✓	✓
	• We will develop an effective preceptorship programme to meet the needs of our students and staff		✓	✓	✓	✓
	• We will complete the annual He audit and report to NMPF	✓	✓	✓	✓	✓
	• We will in conjunction with L&D develop a business case to increase PEF provision	✓				
	• We will allocate staff from each division to attend the Great Day	✓	✓	✓	✓	✓
	• Work with HEI to develop bespoke education modules		✓	✓	✓	✓
	• Matron Lead for Education	✓	✓	✓	✓	✓
	• Promote North west leadership academy courses	✓	✓	✓	✓	✓
	• Include "what is available" for staff (education) in staff communications/ newsletter	✓	✓	✓	✓	✓

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will ensure a competent workforce	• We will develop a standardised Training needs analysis and process across each division signed off by Head of Nursing/ Midwifery	✓	✓	✓	✓	✓
	• We will develop competencies for Nurses, Midwives and HCSW		✓	✓		
	• We will ensure Education is a standing agenda item on NMPF	✓	✓	✓	✓	✓
	• We will review the opportunities for leaders of the future and develop programmes to ensure development of our staff to senior roles	✓	✓	✓	✓	✓
	• We will ensure mandatory training is above the trust target	✓	✓	✓	✓	✓

R- Research

What we want to achieve

We will raise the profile of Nursing, Midwifery and AHP research and Nursing and Midwifery research teams will be included in all aspects of the strategy. We will increase the number of nurses, midwives and AHP's involved in research and audit activity.

Why is this important?

Healthcare institutions that embrace research demonstrates better clinical outcomes. The trusts vision is to foster a research culture and it is important that Nurses, Midwives sand AHP's are part of this culture. *(Research and Innovation strategy- LWH 2018)*

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will raise the profile of research in Nursing, Midwifery and AHPs	• We will support permanent research contracts or part research contracts/ part clinical	✓	✓	✓	✓	✓
	• We will support joint clinical/ research posts		✓	✓	✓	✓
	• Research teams to be included in divisional meetings	✓	✓	✓	✓	✓
	• Research teams to be represented at NMPF and as a standing agenda item	✓	✓	✓	✓	✓
	• Research teams to be included in celebration events/ conferences	✓	✓	✓	✓	✓
	• Introduce Research champions and identify areas to develop and clinical academic roles	✓	✓	✓	✓	✓
	• We will increase the numbers of nurses/ midwives and AHPs undertaking research or developing research ideas		✓	✓	✓	✓
	• Scope and support Nurse and midwives who wish to pursue a master's degree or PhD		✓	✓	✓	✓
	• Consultant Nurse/ Midwives to do a minimum 20% research/ audit/ education activity as part of job plan	✓	✓	✓	✓	✓
	• Increase the number of Nursing and Midwifery research projects		✓	✓	✓	✓
	• Explore joint appointment with LWH and HEI		✓			
	• Quarterly reports to NMPF		✓	✓	✓	✓

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will raise the profile of research in Nursing, Midwifery and AHPs continued	• Showcase research projects – Work up research projects with ideas from clinical areas	✓	✓	✓	✓	✓
	• Create a knowledge centre for grant applications, horizon scanning		✓	✓	✓	✓
	• Consultant Nurse/ Midwife/ AHP champions		✓	✓	✓	✓
How will we achieve this?	**KPI's/ Measurement of success**	**2020**	**2021**	**2022**	**2023**	**2024**
Evidence base practice and Quality improvement	• Develop and monitor Nursing, Midwifery and AHP audit and research programme		✓	✓	✓	✓
	• We will train staff in QI methodology	✓	✓	✓	✓	✓
	• Matron champions for quality improvements	✓	✓	✓	✓	✓
	• Develop a Quality faculty		✓	✓	✓	✓
	• Increase Nursing, Midwifery and AHP specific audits		✓	✓	✓	✓
	• Introduce QI methodology	✓	✓	✓	✓	✓
	• Each area to undertake QI methodology projects to demonstrate and sustain improvements	✓	✓	✓	✓	✓
	• Care pathways or care plans to be evidence based		✓	✓	✓	✓

E- Excellence

What we want to achieve

We will be a strong, credible, innovative and professional workforce who provide safe quality care for our Women, babies, patients, families and carers.

Why is this important?

Measuring the care, we deliver is key to making improvements. Care can always be improved, and it is vital that we show evidence of improvement when needed. Safety of our women, babies, patients and families is paramount. We will recognise, report, empower and protect *(Putting the "safe" into safeguarding- LWH- 2017-2020)*

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will monitor performance	• With performance team we will develop a suite of Nursing and Midwifery performance indicators to be utilised at performance reviews	✓	✓	✓	✓	✓
	• Further Develop the ward accreditation programme	✓	✓	✓	✓	✓
	• Increase the amount of Gold areas		✓	✓	✓	✓
	• Roll out ward accreditation to 5 other areas in 2020 the other areas 2021	✓	✓			
	• Develop peer review process forward audits	✓	✓	✓	✓	✓
	• Reduction in falls by each year on year	✓	✓	✓	✓	✓
	• Reduction in pressure sores year on year	✓	✓	✓	✓	✓
	• Increase breast feeding rates yearly	✓	✓	✓	✓	✓

How will we achieve this?	KPI's/ Measurement of success	2020	2021	2022	2023	2024
We will introduce more Specialist/ advanced/ extended roles to support excellence	• Appoint to TVN/ Nutritional nurse role and develop education for our nurses, midwives and AHP's ion Nutrition and Tissue viability	✓				
	• Increase the amount of Non-Medical prescribers		✓	✓	✓	✓
	• Commit to ensure that every nurse , midwife and AHP has the right skills and knowledge in relation to safeguarding, mental capacity and DOLS- Develop Safeguarding champions in each area	✓	✓	✓	✓	✓
	• Develop information packs for each area – Dementia, Breast feeding, Tissue viability, nutrition		✓	✓	✓	✓
How will we achieve this?	**KPI's/ Measurement of success**	**2020**	**2021**	**2022**	**2023**	**2024**
We will promote innovation	• We will showcase twice yearly the work that we do	✓	✓	✓	✓	✓
	• We will encourage and support new ideas and aspirations from all staff	✓	✓	✓	✓	✓
	• We will ensure networks are attended and ideas, sharing of practice are disseminated	✓	✓	✓	✓	✓
	• We will link in with Liverpool partnership	✓	✓	✓	✓	✓

Delivering the Strategy

There will be an engagement and communications plan to ensure all Nurse, Midwives and AHP's are aware of the strategy. The strategy will be printed but also a plan on a page will be developed for all teams. There will be a launch in November 2019 to co-inside with Kindness day and the launch of fair and just culture and PPF strategy. Each division will develop actions to enable delivery of the strategy.

Monitoring the Strategy

Divisional action plans will be developed with clear responsibilities and how the strategy is going to be delivered which will be monitored monthly at NMPF and quarterly at PPF with an annual report to Board.

Liverpool Women's NHS Foundation Trust

NURSING, MIDWIFERY & AHP STRATEGY 2020-2025- EXAMPLE

Appendix 3 YEAR 1 - 2020- WECARE

" To be a competent, effective and professional workforce, proud to deliver safe, personalised care to meet the needs of our women, babies, families and carers "

W - WORKFORCE	E - EXPERIENCE	C - COMPASSIONATE COMMUNICATION	A - AMBITION	R - RESEARCH	E - EXCELLENCE
Monthly engagement events	actions from picker survey will be completed	Develop expectations of effective communication	Work with HEI to ensure a quality learning environment	Support permanent contracts for research nurses/ midwives	Develop a suite of Nursing, Midwifery & AHP indicators
Bi- Monthly DONM briefings	Increase in response rate of FFT	Roll out SAGE & THYME	Complete annual HE audits	Support joint clinical/ research posts	Further develop ward accreditation programme
Bi- Monthly non-exec walk rounds	Publish FFT feedback in each area	Follow fair and just culture	Allocate staff to attend the great day	Research teams to be included in divisional meetings	Roll out ward accreditation to 5 other areas
Quarterly divisional heads of events	Develop themes from care opinion, pals and pals plus	N, M & AHP strategy as part of everyone's appraisals	Develop bespoke education modules with HEI	Research to be standing agendas item NMPF	Develop peer review process for monthly audits
Visible posters of senior team	Reduce the number of N&M formal complaints	Praise and reward a can-do attitude	Matron lead for education	Research as part of celebration events	Reduction in falls
Links with external stakeholders	Introduce a patient story at NMPF	Develop standardised war/ department meetings and safety huddles	Promote NW leadership academy courses	Research champions	Reduction in pressure sores
Trainee nursing associate role	Develop MVP	Develop MECC champions	Include what is available for staff in staff comms	Consultant Nurses/ Midwives/ AHP's to do a minimum of 20% research/ education/ audit	Increase breast feeding rates
Increase student placements	Increase continuity of carer	Responsive in-patient survey results	Develop standardised training needs analysis signed off by HON/M	Showcase research projects	Appoint TVN/ Nutrition nurse
introduce cadet scheme with Southport college	Develop a Dignity in care Policy	Responsive to FT results	Education is a standing agenda item on NMPF	Train staff in QI methodology	Commit to every nurse/ midwife/ AHP has the right skills, knowledge in relation to safeguarding
Introduce more ACP roles	Introduce Matron shine in all areas	Improve on complaints about staff attitude	Review opportunities for leaders of the future	Matron champion for quality improvement	Showcase our work bi-annually
Prepare teams for new proficiency standards	KPI's for MOG	Encourage pastoral and spiritual support	Mandatory training is above trust target	Each area to undertake at least 1 QI methodology	We will encourage and support new ideas and inn ovations

Liverpool Women's NHS Foundation Trust

	Agenda Item 2019/177
MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Board Assurance Framework**
DATE OF MEETING:	Thursday, 07 November 2019
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Paul Buckingham, Interim Trust Secretary
AUTHOR(S):	Christopher Lube, Head of Governance and Quality
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *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. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE****- People are protected from abuse and harm* ☒ ***EFFECTIVE*** *- people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING*** *- the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ ***RESPONSIVE*** *– the services meet people's needs.* ☒ ***WELL-LED*** *- the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care,* ☒

	supports learning and innovation, and promotes an open and fair culture. ***ALL DOMAINS*** ☐	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: Click here to enter text.
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Trust Board members are requested to review the contents of the paper and gain assurance as to the BAF management process and identify any changes they consider necessary for consideration by the sub-committees.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	The Committees of: Finance, Performance and Business Development, Putting People First Quality Committee
	Date of meeting	October 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 risk on the BAF are set out under strategic aims.

The BAF is based on based on seven key elements:

- Clearly defined Key Priorities for 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 these risk can be managed.
- Potential and positive assurance that risk are being reasonably managed.
- Board reports detailing how risk are being managed and objectives met, together with the identification of gaps in assurances and gaps in control.
- Risk reduction plans, for each risk, which ensures the delivery of the objectives, control of risk and improvements in assurances.
- A target risk rating.

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

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

Report

1. Introduction

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

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

BAF Dashboard: October 2019

Please refer to appendix 1

Full BAF Register – October 2019:

BAF (October 19).PDF

2. Sub-Committee Changes to Risks

Since the last report to the Board, the sub-committees have further reviewed the risks within their remit and there have been some minor changes or alterations completed.

3. New Risks and Closed Risk

Since the last report to the Trust Board the Electronic Patient Record risk has been reviewed by FPBD and it was agreed that the nature of the risk would be further reviewed at the relevant November 2019 Committee meetings.

4. Conclusions

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

The Board are asked to:

The Trust Board members are requested to review the contents of the paper and gain assurance as to the BAF management process and identify any changes they consider necessary for consideration by the sub-committees.

Appendix 1 – BAF Dashboard October 2019

Risk No.	Description	Current risk score			Target	Assurance				Proposed changes - Additions - Removals
		Severity	Likelihood	Risk Score	Risk Score by 31/03/2020	Status	Controls identified	Gap in Controls Identified	Assurances identified	
1663	**Condition:** Failure to deliver the annual financial plan **Cause:** Slippage against CIP targets (inc EPR delivery & CNST contribution reduction); Loss of activity resulting in reduced contribution; Increases in patient activity as contracts are largely on a block basis; Workforce cost pressures; Pressure to deliver national targets; Pension changes for consultants affecting additional activity **Consequence:** Breach of license conditions resulting in financial special measures	5	5	25	10	⟺	Y	Y	Y	Minor updates made
1986	**Condition:** The Trust is not financially sustainable beyond the current financial year **Cause:** Ongoing requirement for annual CIPs; Significant CNST premium; Overhead costs; Impact of service change **Consequence**: Lack of financial stability, invocation of NHSI sanctions, special measures. Continued borrowing to meet operational expenses resulting in significant debt.	5	5	25	25	⟺	Y	Y	Y	Minor updates made
2184	**Condition:** Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) by the proposed schedule May 2020 which may lead to the implementation of a system that is not fit for purpose **Cause:** Poor programme management and product design **Consequence:** Impact on Patient Safety, Quality and Experience; Impact on patient clinical services, such as e-prescribing, staff documentation and consent; Unable to meet contractual reporting arrangements linked to performance and finance; Financial impact on delivery of control total leading to inability to deliver annual plan.	5	5	25	25	⟺	Y	Y	Y	Risk reviewed by FPBD and it was agreed that the nature of the risk would be further reviewed at the relevant November 2019 Committee meetings.
2266	**Condition:** Ineffective understanding and learning following significant events **Cause:** Failure to identify root cause, system structures and process, failure to analyse thematically, failure to respond proportionately. **Consequence:** Patient harm, failure to learn and improve the quality of service and experience, poor quality services, loss of income and activity, reputational damage, increased staff turnover.	4	3	12	6	⟺	Y	Y	Y	One action was closed in relation to divisional review of implementation of lessons learnt to divisional assurance as to lesson learnt.
2293	**Condition:** Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust. **Cause**: Poor staff morale, lack of clarity around objectives, lack of ability to influence in the workplace, lack of organisational/job security, lack of leadership, behaviour contrary to the Trust values. **Consequence:** Failure to deliver high quality, safe patient care, impact on recruitment and retention, failure to achieve strategic vision, potential for regulatory action and reputational damage.	5	2	10	10	⟺	Y	Y	Y	Minor updates made

Risk No.	Description	Current risk score			Target	Assurance				Proposed changes - Additions - Removals
		Severity	Likelihood	Risk Score	Risk Score by 31/03/2020	Status	Controls identified	Gap in Controls Identified	Assurances identified	
2294	**Condition**: Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes. **Cause:** Insufficient numbers of doctors in training; Aging workforce; National shortage of nurses and midwives; Isolated site and associated clinical risk impacting on recruitment and retention of specialist consultant staff; pension tax changes impacting on the retention of consultant medical staff (early retirement or reduction in working time). **Consequence:** Gaps on junior doctor rotas; Loss of highly experienced nursing staff due to retirement; Impact on the quality of junior doctors in training; This may result in unsafe patient care and less effective outcomes, status of teaching hospital and impact on retention of specialist services.	5	4	20	10	⟺	Y	Y	Y	Minor updates made
2295	**Condition:** Inability to achieve and maintain regulatory compliance, performance and assurance. **Cause:** Lack of robust processes and management systems to provide evidence and assurance to regulatory agencies. **Consequence:** Enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.	4	3	12	8	⟺	Y	Y	Y	Minor updates made New CQC compliance assessment module nearing completion and implementation in Jan 2020
2297	**Condition:** Location , size, layout an accessibility of current services do not provide for sustainable integrated care or safe and high quality service provision. **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. **Consequence:** Patient harm, poor continuity of care, poor patient experience due to transfer away for booking location.	5	4	20	20	⟺	Y	Y	Y	Minor updates made

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Financial Services | **Service / Department:** Finance | **Position at:** 31/10/2019 06:50:46

Risk Number: 1663 **Version:** 21 **Domain:** Finance Including Claims

Strategic Objective: To Be Ambitious & Efficient & Make Best Use Of Available Resources

Risk Appetite: 3.Moderate

Risk Description:

Condition: Failure to deliver the annual financial plan

Cause: Slippage against CIP targets (inc EPR delivery & CNST contribution reduction); Loss of activity resulting in reduced contribution; Increases in patient activity as contracts are largely on a block basis; Workforce cost pressures; Pressure to deliver national targets; Pension changes for consultants affecting additional activity

Consequence: Breach of license conditions resulting in financial special measures

Executive Lead: Jenny Hannon **Operational Lead:** Eva Horgan

Assurance Committee: Finance, Performance & **Review Due:** 30/11/2019

Last Review Narrative: **Date:** 25/10/2019 **Reviewed By:** Christopher Lube

Review completed, no updates required at this time, all actions in progress.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Robust Budget setting process Quality Impact Assessment of all CIPs and post evaluation reviews Sign off of budgets by accountable officers FPBD and Board approval of budgets Budget Holder Training programme in place Monthly reporting to all budget holders with variance analysis Monthly reporting to FPBD and Trust Board Monthly reporting and feedback from NHSE/I Vacancy control process well established and monitored Control of expenditure through activity monitoring spends Monthly performance meetings Divisional performance reviews	Lack of contingency in budgets External influences and national policy	Not Yet Tested	2019/20 Budget approval (BoD - April 19) Budget holder training manual and attendance records Performance and finance reports (monthly to FPBD and BoD) Finance and CIP achievement (Monthly to FPBD) Executive Team and Board oversight Internal Audit report provides significant assurance (Oct 17) Sustained performance above plan Delivery of control total in previous years	Monthly reports to NHSI with feedback Internal audit review of budgetary controls External Audit opinion	Assurance is available re; controls, but is not on delivery Delivery of control total in 19-20 Delivery of £3.6m CIP for 19-20 NHSI use of resources risk rating - 3	Inconclusive
Detect	Internal audit reviews of systems and controls	None Known	Effective	Performance and Finance Reports to FPBD	External Audit Opinion	Assurance is available on controls but not on delivery	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Ongoing review of position in Divisional Performance meetings and finance committee	01/05/2019	31/03/2020	Eva Horgan	Ongoing monthly monitoring Action rewritten following exec review and risk being placed back onto Ulysses. Date Entered : 09/08/2019 14:43 Entered By : Christopher Lube	Ongoing	/ /
2	Quality performance challenge meetings	01/04/2019	31/03/2020	Eva Horgan	Ongoing monthly monitoring Date Entered : 09/08/2019 14:45 Entered By : Christopher Lube	Ongoing	/ /
3	Ongoing review of CIP	01/04/2019	31/03/2020	Eva Horgan	Ongoing monthly review Date Entered : 09/08/2019 14:46 Entered By : Christopher Lube	Ongoing	/ /
4	Monthly budget meeting with variance analysis	01/04/2019	31/03/2020	Eva Horgan	Ongoing monthly monitoring Date Entered : 09/08/2019 14:47 Entered By : Christopher Lube	Ongoing	/ /

Initial Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	5 Almost	25

Target Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	2 Unlikely	10

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Financial Services | **Service / Department:** Finance | **Position at:** 31/10/2019 06:50:46

Risk Number: 1986 **Version:** 5 **Domain:** Finance Including Claims

Strategic Objective: To Be Ambitious & Efficient & Make Best Use Of Available Resources

Risk Appetite: 3.Moderate

Risk Description:

Condition: The Trust is not financially sustainable beyond the current financial year

Cause: Ongoing requirement for annual CIPs; Significant CNST premium; Overhead costs; Impact of service change

Consequence: Lack of financial stability, invocation of NHSI sanctions, special measures. Continued borrowing to meet operational expenses resulting in significant debt.

Executive Lead: Jenny Hannon **Operational Lead:** Eva Horgan

Assurance Committee: Finance, Performance & **Review Due:** 30/11/2019

Last Review Narrative: **Date:** 25/10/2019 **Reviewed By:** Christopher Lube

Review completed, no updates required at this time, all actions in progress.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	5 Year financial model produced giving early indication of issues Business case to Trust Board which identifies a solution which minimised deficit, including relocation to an acute site and merger Early and continuing dialogue with NHSE/I Active engagement with CCG resulting in a pre-consultation Business Case Agreement for merger proposals with partner Trusts approve by three BoD's Advisors with relevant experience (PWC) engaged early to review strategic options Clinical Engagement and support for proposals Review of open claims and legal processes Engagement in place with Cheshire and Mersey Partnership to review system solutions Update review against clinical standards and financial consequences. Reduction in CNST Premium Reduction in back office overheads costs.	Implementation of business case is dependent on decision making external to the Trust (CCG, NHSE/I) Uncertainty regarding availability of capital funding necessary to implement business case Establishment of governance procedures to manage the merger transaction Merger dependent on external partners National CDEL Issue.	Not Yet Tested	5 Year plan Approval (BoD, Nov 2014) resubmission due Sept 19 Future Generations Clinical Strategy and Business Plan (BoD Nov 15) Sustainability and Transformation Plan (FPBD, Jul 16) PCBC Approval (FPBD, Oct 16) Strategic Outline Case for merger approved by three Trust Boards (BoD, Jun 16) SCO for preferred option approved by Board - Sept 17 Submission of Cheshire and Mersey STP capital bid Summer 2018 ranked no1 Clinical Senate report -Sept 17	CCG Pre Consultation Business Case approved by CCG Committees in common Northern Clinical Senate Report supporting preferred option Cheshire and Mersey Partnership Support	Final approval for business case Lack of capital nationally Delivery of surplus NHSE/I use of resources rating above 3 over a five year period	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
4	Revision of SOC following unsuccessful STP capital bid Target has been put back based on initial feedback from TU readiness assessment - system buy in to be initial focus ahead of SOC update.	01/04/2019	31/12/2019	Eva Horgan	Work ongoing Date Entered : 09/08/2019 14:11 Entered By : Christopher Lube	Ongoing	/ /
5	Approval of revised capital route	01/04/2019	30/11/2019	Eva Horgan	Work ongoing Date Entered : 09/08/2019 14:12 Entered By : Christopher Lube	Ongoing	/ /
6	Public consultation by CCG following development of preferred option (Subject to capital bid)	01/04/2019	30/04/2020	Eva Horgan	Dependent on external influences and agencies Date Entered : 09/08/2019 14:14 Entered By : Christopher Lube	Ongoing	/ /
7	Decision making business case produced by CCG and final decision following outcome of public consultation required	01/04/2019	31/12/2020	Eva Horgan	Closely linked to other actions and external influences Date Entered : 09/08/2019 14:16 Entered By : Christopher Lube	Ongoing	/ /
8	Business case to support the application for capital to support the relocation required	01/04/2019	31/03/2020	Eva Horgan	Timescale TBC - requirements to be confirmed, subject to outcome of bid. Date Entered : 09/08/2019 14:18 Entered By : Christopher Lube	Ongoing	/ /
9	Merger Transaction	01/04/2019	01/04/2020	Eva Horgan	Actual timescale is April 2021 - subject to NHSI approval. Monitor monthly as part of ongoing overall	Ongoing	/ /

10	Implementation of changes	01/04/2019	01/04/2020	Eva Horgan	risk review Date Entered : 09/08/2019 14:21 Entered By : Christopher Lube Actual timescale April 2021-2026, monitor as part of overall monthly risk review Date Entered : 09/08/2019 14:22 Entered By : Christopher Lube	Ongoing	/ /

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Target Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** IM & T | **Service / Department:** IM & T | **Position at:** 31/10/2019 06:50:46

Risk Number: 2184 **Version:** 3 **Domain:** Impact On The Safety Of Patien

Executive Lead: Andrew Loughney **Operational Lead:** Steve Chokr

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 29/11/2019

Risk Description:

Condition: Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) by the proposed schedule May 2020 which may lead to the implementation of a system that is not fit for purpose

Cause: Poor programme management and product design

Consequence: Impact on Patient Safety, Quality and Experience; Impact on patient clinical services, such as e-prescribing, staff documentation and consent; Unable to meet contractual reporting arrangements linked to performance and finance; Financial impact on delivery of control total leading to inability to deliver annual plan.

Last Review Narrative: **Date:** 30/10/2019 **Reviewed By:** Steve Chokr

No changes made to current risk, actions ongoing.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	EPR programme board chaired by AUHT CEO and attended by LWH Exec Dir, CIO and CCIO. Governance structure for project in place with independent reviews LWH Digital sub-committee review of project in place with DoF chairing Oversight of programme by FPBD (inc NEDs) Monthly IM&T mangers operational meetings in place PID in Place Testing programme for system in place prior to implementation Communication plan in place Benefit Strategy Clinical leadership identified Training and engagement plan in place	Concern as to supplier management and product functionality UK market Programme board ineffectiveness Lack of confidence in plan Test cycle may be ineffective and if not signed off will impact on programme Unable to train staff until system has been signed off which may lead to a delay Key partner waiting NHSI approval and has not agreed contract with supplier	Effective	Executive sign off initial programme plan Clinical (operational) sign off Exec team briefing from CIO Oversight from digital hospital sub-group Regular reporting to FPBD Clinician engagement undertaken	MIAA Gateway reviews MIAA Report (limited assurance) 2017 Gateway process in place with external verification NHS Digital review (March 19) Independent review to Director of Finance (April 19)	Ability to influence supplier Functionality of modules for Maternity, Theatres and e-prescribing Appetite of other Trust to prioritise the program Effectiveness of program Board in delivering the solution Effectiveness of supplier and product as evidenced by Digital and Independent reports. Subjectivity of progress	Negative

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
2	Recommendations of NHS Digital follow up report	21/02/2018	31/12/2019	Steve Chokr	NHS Digital report suggested a go.no go decision be postponed until Oct pending further actions to address the outstanding issues. Date Entered : 13/08/2019 14:01 Entered By : Sandra Goulden ---------- Action reviewed and updated in line with moving BAF back onto Ulysses. Date Entered : 08/08/2019 15:52 Entered By : Christopher Lube ---------- Integrated EPR remains a key issue for LWH. Programme Board notes and is managing the delays in implementation. Date Entered : 15/02/2019 13:11 Entered By : Andrew Loughney	Ongoing	/ /
4	Delivery of live system against design and configuration through the programme and clinically signed off	21/02/2018	31/05/2020	Andrew Loughney	Action reviewed and updated in line with moving BAF back onto Ulysses. Date Entered : 08/08/2019 15:57 Entered By : Christopher Lube ---------- Action plan and sub logs are available and viewed by Programme Board. Achieving set	Ongoing	/ /

					targets remains problematic. Date Entered : 15/02/2019 13:13 Entered By : Andrew Loughney		
5	Test system built and tested against clinically approved script with additional scrutiny and assurances around areas highlighted as a concern.	21/02/2018	30/04/2020	Andrew Loughney	Action reviewed and updated in line with moving BAF back onto Ulysses. Date Entered : 08/08/2019 15:55 Entered By : Christopher Lube ---------- Test cycles in several steps, progress being monitored by Programme Board. Date Entered : 15/02/2019 13:14 Entered By : Andrew Loughney	Ongoing	/ /
6	Completion of business intelligence strategy to enable the successful delivery of statutory and operational reporting post deployment	21/02/2018	31/05/2020	Steve Chokr	Business Intelligence functionality remains unproven, Programme Board is monitoring. Date Entered : 15/02/2019 13:15 Entered By : Andrew Loughney	Ongoing	/ /
8	Recommendation to Trust Boards from EPRL Programme Board following review of Digital report and actions to continue or not	01/09/2018	31/12/2019	Steve Chokr	Exec team and board are reviewing and awaiting updated. Date Entered : 30/10/2019 12:23 Entered By : Steve Chokr ---------- SG 13/8/19 NHS Digital report suggested that there was not enough evidence to cease or to approve, Oct Board is the next decision point for go/no go. Date Entered : 13/08/2019 13:59 Entered By : Sandra Goulden ---------- Action reviewed and updated in line with moving BAF back onto Ulysses. Date Entered : 08/08/2019 15:58 Entered By : Christopher Lube ---------- EPR being managed at Exec and Board level. New EPR go-live date for LWH now May 2020. Red line items for Pharmacy and Theatres still being managed a progress being monitored. Any impact to new go-live date will be articulated through FPBD and onto Board. Date Entered : 05/03/2019 16:12 Entered By : Steve Chokr	Ongoing	/ /

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	4 Likely	20

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Target Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Listing For: 4.BAF **Risk Register Level:** 4. BAF **Directorate:** Governance **Service / Department:** Governance **Position at:** 31/10/2019 06:50:46

Risk Number: 2266 **Version:** 1 **Domain:** Impact On The Safety Of Patien

Executive Lead: Devender Roberts **Operational Lead:** Christopher Lube

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 29/11/2019

Risk Description:

Condition: Ineffective understanding and learning following significant events

Cause: Failure to identify root cause, system structures and process, failure to analyse thematically, failure to respond proportionately.

Consequence: Patient harm, failure to learn and improve the quality of service and experience, poor quality services, loss of income and activity, reputational damage, increased staff turnover.

Last Review Narrative: **Date:** 30/10/2019 **Reviewed By:** Christopher Lube

Work continues with the Division to ensure lesson learnt form incidents are identified and shared. Risk Management Web Site to be reviewed and updated. Lesson Learnt site on Trust web site being updated, New Risk an patient Safety Manager has been appointed to commence 02/01/20 who will take lead on lesson learnt and linking with Quality Improvement.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Regular dialogue with regulators. Incident reporting and investigation policies and procedures. MDT involvement in safety HR policies in relation to issues relating to professional and personal responsibility Mandatory training in relation to safety and risk Staffing level acuity exercises Scoping for relevant national reports Quality strategy 3yr programme in place Risk Management Strategy Governance structure Serious Incident Feedback form Serious Incident panels Corporate level engagement by Trust Board Listening events Never events reported though Safety Senate and BoD 2nd Year of Quality strategy delivered Safety is included as part of executive walk rounds. Close working with safety collaborative being maintained	Inconsistent completion and dissemination of actions and improvement plans Inconstant implementation of lessons learnt and lack of evidence Pace of implementing change, Monitored via effectiveness senate Lack of opportunity to deliver bespoke training for staff groups in relation to risk management and patient safety.	Effective	CQPG Meetings Reporting of incidents and management of action plans through Safety Senate Reflection of risks and Corporate Risk Register and Board Assurance Framework CQC Assessment Annual Quality Account Report	Internal Audit of Risk Management External Audit or Risk Maturity CQC Assessment, safe as 'Good' across all areas of the Trust NRLS Incident Reporting MIAA Report on Duty of Candour Safety Senate Reports	Inconsistent use of benchmarking tools Difficult to gain consistent assurance that clinicians are following best practice Some national audits/studies do not provide benchmarking of data if they do, this is in an inconsistent format making it difficult to accurately assess and compare Trust status Lack of testing of action plans following audits to ensure they lead embedded change External and internal reporting structures.	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Introduction of Fair and Just Culture process	01/04/2019	31/10/2024	Chris McGhee	Initial stages of training staff via book clubs in progress. Mapping exercise of SI ongoing Date Entered : 31/07/2019 10:57 Entered By : Christopher Lube	Ongoing	/ /
2	Maintain close involvement with regional and local safety collaborative	01/04/2019	01/04/2020	Alan Clark	Links with Safety collaboratives re being maintained, this has become a control. Date Entered : 30/09/2019 17:47 Entered By : Christopher Lube ---------- Working is ongoing in this area. New NHS Patient safety strategy published which highlights this action. Trust local implementation plan in development Date Entered : 31/07/2019 10:58 Entered By : Christopher Lube	Completed	30/09/2019
3	Develop better reporting from the Ulysses System	01/04/2019	31/12/2019	Christopher Lube	The Upgrade of the Ulysses system is progressing. A slight delay was encountered due to the need to move to a new server.	Ongoing	/ /

					Date Entered : 30/10/2019 14:47 Entered By : Christopher Lube ---------- Governance team currently working with Ulysses to develop the current system and implement new modules to support RCA investigation, Action Planning and CQC compliance monitoring, Audit module to come later in year.		
4	New divisional structure to review implementation of lessons learnt and provision of evidence	01/04/2019	30/09/2019	Christopher Lube	Date Entered : 31/07/2019 10:56 Entered By : Christopher Lube Action completed as divisions in place and have established governance groups. New action developed. Date Entered : 30/09/2019 17:50 Entered By : Christopher Lube ---------- Review of SI learning and complaint learning requested via divisional performance meetings.	Completed	30/09/2019
5	Divisions to undertake gap analysis of risk management resources	01/04/2019	31/12/2019	Christopher Lube	Date Entered : 31/07/2019 10:58 Entered By : Christopher Lube Review ongoing, Secondment to be provided for CSS, interviewing for Risk and Pt Safety Managers post, Replacement for Gov Man (Mat) commencing in post 7th Nov 19. Date Entered : 03/10/2019 16:40 Entered By : Christopher Lube ---------- Review being led buy Head of Governance in line with new divisional structures.	Ongoing	/ /
6	Business case for the provision of Human Factors Training to be developed and submitted to education governance committee	01/04/2019	31/12/2019	Linda Watkins	Date Entered : 31/07/2019 10:59 Entered By : Christopher Lube There is currently no lead for SIM Training in Trust, Lead for action has been changed to Chair of Ed Gov Comm. Date Entered : 03/10/2019 16:38 Entered By : Christopher Lube ---------- Update Received from Dr Hurst as to current position of Simulation Tranining. See Document section for further detail. Date Entered : 14/08/2019 14:19 Entered By : Elaine Eccles ---------- Initial paper presented to Ed Gov and Safety Senate, acting Medical Director requested further	Ongoing	/ /

					information Date Entered : 31/07/2019 11:01 Entered By : Christopher Lube			
7	New risk management and patient safety training package to be developed	01/04/2019	31/12/2019	Christopher Lube	Work is ongoing, plan for completion Nov 19 Date Entered : 03/10/2019 16:39 Entered By : Christopher Lube ---------- Head of Governance in planning stages. May be affected by new national training system and curriculum which is due to be published in 2019-20. Date Entered : 31/07/2019 11:00 Entered By : Christopher Lube	Ongoing	/ /	
8	Divisions to report process for the dissemination of actions, lessons learnt and improvement plans	30/09/2019	31/12/2019	Christopher Lube	Process for the dissemination for lessons learnt, actions and improvement plans requested from Divisions by HoG&Q Date Entered : 30/09/2019 17:54 Entered By : Christopher Lube		/ /	

Initial Assessment		
Severity	Likelihood	Risk Score
4 Major	5 Almost	20

Current Assessment		
Severity	Likelihood	Risk Score
4 Major	3 Possible	12

Target Assessment		
Severity	Likelihood	Risk Score
3 Moderate	2 Unlikely	6

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Human Resources | **Service / Department:** HR | **Position at:** 31/10/2019 06:50:46

Risk Number: 2293 **Version:** 2 **Domain:** HR/Organisational Development/

Strategic Objective: Develop A Well-Led, Capable, Motivated And Entrepreneurial Workforce

Risk Appetite: 3.Moderate

Risk Description:

Condition: Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust.

Cause: Poor staff morale, lack of clarity around objectives, lack of ability to influence in the workplace, lack of organisational/job security, lack of leadership, behaviour contrary to the Trust values.

Consequence: Failure to deliver high quality, safe patient care, impact on recruitment and retention, failure to achieve strategic vision, potential for regulatory action and reputational damage.

Executive Lead: Michelle Turner **Operational Lead:** Jeanette Chalk

Assurance Committee: Putting People First **Review Due:** 29/11/2019

Last Review Narrative: **Date:** 30/10/2019 **Reviewed By:** Simon Davies

No changes made to current risk, actions ongoing.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Appraisal policy, paperwork and systems for delivery and recording are in place for medial and non-medical staff. Consultant revalidation process. Reward and recognition processes linked to values. Pay progression linked to mandatory training compliance. Targeted OD intervention for areas in need to support. Management development training programme. Aspirant talent programme for aspiring ward managers and matrons. Programme of health and wellbeing initiatives. All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities. Extensive mandatory training programme available. Value based recruitment and induction. Workforce planning processes in place to deliver safe staffing. Shared decision making with JLNC and Partnership Forum. Putting People First Strategy. Quality Strategy. Guardian of Safe Working. People strategy revised and agreed	Quality of appraisal. Poor attendance at non-mandatory training e.g. leadership training. Requirement for further development of middle managers. Talent management programme is newly implemented and not yet fully embedded.	Effective	Quarterly internal staff survey (Go Engage System). Monthly KPI's for controls. Performance Repots (monthly) Quarterly Learning events. Bi-annual Speak UP Guardian Reports. Report form Guardian of Safe Working	National Staff Survey(annual). POPPY study RCM culture survey findings CQC regulatory inspection in 2018. National Workforce and Wellbeing Charter - 2018	Staff survey engagement score not improved in year. Mandatory training currently below target. Sickness absence above target.	Positive
Detect	Recruitment intentions annual exercise. Staff engagement programmes. Two Freedom to Speak Up Guardians. Whistle Blowing Policy Engagement Tool Implemented.	Ongoing challenges of engaging effectively with all staffing groups due to rota patterns.	Effective				

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	PPF deep dive into service level workface risks	01/04/2019	31/03/2020	Jeanette Chalk	To be completed on a monthly basis Date Entered : 08/08/2019 11:31 Entered By : Christopher Lube	Ongoing	/ /
2	Aspirate managers programme being rolled out	01/04/2019	31/03/2020	Jeanette Chalk	To be monitored monthly Date Entered : 08/08/2019 11:33 Entered By : Christopher Lube	Ongoing	/ /
3	Executive team and staff side walkabouts	01/04/2019	31/03/2020	Jeanette Chalk	To be monitored monthly Date Entered : 08/08/2019 11:35 Entered By : Christopher Lube	Ongoing	/ /
4	Launch of Fair and Just Culture Project	01/04/2019	31/03/2020	Chris McGhee	Initial development work and staff training in progress Date Entered : 09/08/2019 15:24 Entered By : Christopher Lube		/ /

Initial Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	2 Unlikely	10

Target Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	2 Unlikely	10

Listing For: 4. BAF **Risk Register Level:** 4. BAF **Directorate:** Human Resources **Service / Department:** HR **Position at:** 31/10/2019 06:50:46

Risk Number: 2294 **Version:** 3 **Domain:** HR/Organisational Development/

Strategic Objective: Develop A Well-Led, Capable, Motivated And Entrepreneurial Workforce

Risk Appetite: 3.Moderate

Risk Description:

Condition: Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes.

Cause: Insufficient numbers of doctors in training; Aging workforce; National shortage of nurses and midwives; Isolated site and associated clinical risk impacting on recruitment and retention of specialist consultant staff; pension tax changes impacting on the retention of consultant medical staff (early retirement or reduction in working time).

Consequence: Gaps on junior doctor rotas; Loss of highly experienced nursing staff due to retirement; Impact on the quality of junior doctors in training; This may result in unsafe patient care and less effective outcomes, status of teaching hospital and impact on retention of specialist services.

Executive Lead: Michelle Turner **Operational Lead:** Jeanette Chalk

Assurance Committee: Putting People First **Review Due:** 29/11/2019

Last Review Narrative: **Date:** 30/10/2019 **Reviewed By:** Simon Davies

No change made to current risk. Actions ongoing - awaiting outcome of bid to NHSI for capitol funding (due in November).

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Annually agreed funding contract with HEN. Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer. Lead Employer notifies the Trust of Gaps in local rotations, giving the Trust autonomy to recruit at a local level into these gaps. Effective electronic rota management system implemented. Director of medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN. Guardian of Safe Working Hours appointed in 2016 under new Junior Doctor Contract. Acting down policy and process in place to cover junior doctor gaps. National Revalidation process ensuring competent staff. Shared decision making and review of risk with JLNC. Putting People First Strategy. Quality Strategy. Strategic Workforce Group established. Aspirational Ward Manager Programme. Succession Planning and Talent Programme NHSE Retention Improvement Programme NHSI Sickness Improvement Programme	Further utilisation of the rota management system. E-Roistering System not fully utilised	Effective	Quarterly reporting by Guardian of Safe Working. Strategic Workforce reporting to PPF. Leadership Development programme Review (annual to PPF). Exception Reporting System and process working effectively. Junior Medical Staff GMC survey reporting to Education Governance and PPF - No concerns areas of specific concerns identified. Clinical and nursing roles being developed and enhanced to mitigate the gas in junior doctor workforce. Roles include: Physicians Assistants, Surgical assistants, ANP's, Consultant Nurses, ER Practitioners.	DME reports to HEN on an annual basis in relation to junior doctor training. Annual GMC Survey. Annual Staff survey NHS Ed SAR. DME Annual Report GMC Revalidation Process HEN Visit - Regular (next due 2019 due to satisfactory report in 2016) GMC Medical Staff survey - annual.	None identified at this time	Positive
Detect	GMC Survey 018 - action plan in place						

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Action plan from strategic group	01/04/2019	31/03/2020	Jeanette Chalk	To be monitored monthly Date Entered : 08/08/2019 12:14 Entered By : Christopher Lube	Ongoing	/ /
3	Business case to go to NHSI to develop E-Rostering System Collaborative work with CMHRD Network. Health and Care Partnership for Cheshire and Merseyside have indicated that we will not be able to submit a business case to develop for E-Rostering. Reviewing situation. Due date: end of September 2019. The Trust submitted a bid for capital funding to implement eRostering software across the medical workforce to the NHSI capital funding for workforce deployment systems on 24.09.2019. SMT approved the business case to fund the ongoing system costs should the bid be successful. Bid outcomes are due in November 2019 (no specific date given).	01/04/2019	30/11/2019	Kathryn Allsopp	Work is ongoing Date Entered : 09/08/2019 15:25 Entered By : Christopher Lube	Ongoing	/ /

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	4 Likely	20

Target Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	2 Unlikely	10

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Governance | **Service / Department:** Governance | **Position at:** 31/10/2019 06:50:46

Risk Number: 2295 **Version:** 1 **Domain:** Impact On The Safety Of Patien

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Risk Description:

Condition: Inability to achieve and maintain regulatory compliance, performance and assurance.

Cause: Lack of robust processes and management systems to provide evidence and assurance to regulatory agencies.

Consequence: Enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.

Executive Lead: Caron Lappin **Operational Lead:** Christopher Lube

Assurance Committee: Quality Committee **Review Due:** 14/11/2019

Last Review Narrative: **Date:** 15/10/2019 **Reviewed By:** Christopher Lube

CQC PIR submitted, await Unannounced and Well Led Inspections. For further review following outcome of inspection.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Detect	Board Assurance visits NED walk rounds National Audits Local Audits Ward accreditation scheme H&S Executive inspections Human Tissue and Embryology Authority Inspections External Peer reviews CQC inspections	None identified	Effective		MIAA Audits Collaborative meetings with CCG CQC Inspections NHSE/I reviews with LWH	None identified	Positive
Prevent	Regular meetings with NHSE/I CQC engagement meetings Maintenance of CQC registration Regulatory information provided to staff at induction Committee structures in place to monitor regulatory compliance An integrated approach between corporate operational and governance teams Quality impact assessments for all service changes and CIP's that are considered. Professional Standards Trust Polices and Procedures Risk Management Strategy and culture Quality and Independence of QIA's by DoN and MD Completion and submission of Annual Quality Report	Benchmarking data can make the Trust appear an outlier due to specialist nature of the services provided and attract regulatory attention	Effective	Executive Walk rounds Matron walk rounds Ward accreditation Internal H&S walk rounds and annual audits Internal Fire Safety Inspection's	MIAA Audits CQC Visits CCG Meetings HFEA Inspections H&S Executive inspections Fire Service Inspections Safeguarding regulatory Inspections	Monitoring of regulatory reports and action plans to completion	Positive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Provide assurance to CQC in relation to risk with appropriate information	01/04/2019	31/03/2020	Christopher Lube	Information provided to CQC on request and at quarterly engagement meetings. Action to be monitored monthly Date Entered : 08/08/2019 14:57 Entered By : Christopher Lube	Ongoing	/ /
2	Ward accreditation to be rolled out following completion of pilot	01/04/2019	31/03/2020	Janet Brennan	Meeting with Ward Accreditation providers due on 08/08/19. Progress on pilot to be discussed and review of software to log data. Date Entered : 08/08/2019 15:00 Entered By : Christopher Lube	Ongoing	/ /
3	To embed process for monitoring of regulatory reports and action plans at divisional boards	01/04/2019	31/03/2020	Christopher Lube	New CQC compliance monitoring module being developed by Ulysses. Due for implementation in September 2019. Date Entered : 08/08/2019 15:02 Entered By : Christopher Lube	Ongoing	/ /

4	Report regulatory exceptions form Divisional Boards to Quality Committee	01/04/2019	31/03/2020	Christopher Lube	Once CQC compliance module in place in Ulysses Divisions will be able to provide exception report to Quality Committee on status and planned actions. Date Entered : 08/08/2019 15:05 Entered By : Christopher Lube		Ongoing	/ /
5	Undertake intermittent deep dive reviews into specialist services	01/04/2019	31/03/2020	Christopher Lube	Reviews to be completed as and when identified by sub-committee of the board or at divisional board level. Date Entered : 08/08/2019 15:08 Entered By : Christopher Lube		Ongoing	/ /

Initial Assessment		
Severity	Likelihood	Risk Score
4 Major	5 Almost	20

Current Assessment		
Severity	Likelihood	Risk Score
4 Major	3 Possible	12

Target Assessment		
Severity	Likelihood	Risk Score
4 Major	2 Unlikely	8

Listing For: 4.BAF **Risk Register Level:** 4. BAF **Directorate:** Governance **Service / Department:** Executive Office **Position at:** 31/10/2019 06:50:47

Risk Number: 2297 **Version:** 1 **Domain:** Impact On The Safety Of Patien

Executive Lead: Andrew Loughney **Operational Lead:** Devender Roberts

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 29/11/2019

Risk Description:

Condition: Location , size, layout an accessibility of current services do not provide for sustainable integrated care or safe and high quality service provision.

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.

Consequence: Patient harm, poor continuity of care, poor patient experience due to transfer away for booking location.

Last Review Narrative: **Date:** 30/10/2019 **Reviewed By:** Devender Roberts

Three new risks have been added to the Corporate Risk Register - GynaeOncology Consultant cover, Networked Maternal Medicine services and 7DS compliance - standard 5&6 which are co-location standards. Action complete

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Early and continuing dialogue with regulators Active management with CCG's Putting People First Strategy Environmental risk assessments Leadership and Management development programme Programme for the establishment of single service for Neonates with AHCH. Adult services Access to RLBUHT for diagnostic services such as imaging. Blood product provision by motorised vehicle from near by facility. Well established methods for detecting deterioration in patients and arranging escalation/transfer Access to RLBUHT for surgery for women with advanced pelvic cancers and severe co-morbidities. Neonatal services Early detection of neonates with deteriorating condition Close contacts with AHCH Transfer Arrangements well established	STP submission for capital bid completed in Nov 18 - not successful Clinical case for change is dependent on decision making external to the Trust (NHSE/I, CCG) Financial constraints for delivery of facilities on site. Development of crown site impracticable in relation to imaging, ITU, blood back and staffing unlikely to be achievable.	Not Effective	Corporate Objectives 2019-20 Board performance reports DIPC Reports Staffing reports to board Incident and SI reports to Safety Senate and Board. Mortality and Morbidity reviews Performance monitoring of patient experience and clicnial outcomes Incident Data Staff staffing levels Transfers out Data reviewed regularly and reported through HDU and Sepsis Group.	CQC inspection (2018) - Good Review of Fire Safety Provision Van giard review of Maternity Base Neonatal ODM Maternity SCN Dashboard Clcinail Senate Report NICU SOC Neonatal Peer review Jan 18.	Gaps in fire prevention (SLA with Aintree estates in place, review completed and risk assessed with generation of priorities , presented to execs Dir - Jan 18) Failure to meet BAPM standards Non-compliance with HBN accommodation standards on NNU Consultant presence on delivery suite Transfers of complex cancer patients Failure to meet RCOA Standards for Care of Women Critically Ill and Women in Childbirth - Aug 18.	Negative
Contingency	Adult services Longstanding/historical support fro RLBUHT and AUH (senior medial and surgical) clinicians to provide acute, elective support when required. Attendance of RLBUHT to LWH site in acute case or need Abilities to transfer actually ill patient to RLBUHT for care						

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	To commence public consultation (external control of this action by NHSE/I)	01/04/2019	31/03/2020	Devender Roberts	To be monitored monthly Date Entered : 09/08/2019 13:40 Entered By : Christopher Lube	Ongoing	/ /
2	Agree Business Case for new build	01/04/2019	31/03/2020	Devender Roberts	To be monitored monthly Date Entered : 09/08/2019 13:41 Entered By : Christopher Lube	Ongoing	/ /
3	Await and review outcome of clinical summit (June 19)	01/04/2019	31/10/2019	Devender Roberts	Action has been closed and replaced with new action related to further summit work Date Entered : 27/09/2019 08:34 Entered By : Christopher Lube ---------- Issue discussed at Medical Staffing Committee following summit. Interim Medial Director reviewing outcome of Summit	Completed	27/09/2019

					Date Entered : 29/08/2019 10:38 Entered By : Christopher Lube ---------- Clinical Summit has taken place			
4	Divisional plans to be developed to support long term clinical sustainability	01/04/2019	31/12/2019	Devender Roberts	Date Entered : 09/08/2019 13:44 Entered By : Christopher Lube Work ongoing in Divisions Date Entered : 09/08/2019 13:46 Entered By : Christopher Lube	Ongoing	/ /	
5	Outcomes form the clinical summit to be actioned.	27/09/2019	31/12/2019	Devender Roberts	Acting Medical Director working with Strategic Finance Manager on reviewing summit outcomes. Date Entered : 27/09/2019 08:43 Entered By : Christopher Lube		/ /	
6	Develop new BAF risk for Gynae Oncology consultant cover, Maternal Medicine and & Day Service compliance. To be reviewed by Quality Committee.	27/09/2019	31/10/2019	Devender Roberts	Acting Medical Director and Head of Governance have met and developed BAF risks. To go to October QC for review. Date Entered : 27/09/2019 08:41 Entered By : Christopher Lube		/ /	

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	4 Likely	20

Target Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	4 Likely	20