NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

Board of Directors Meeting

HELD ELECTRONICALLY

7 May 2020

Meeting of the Board of Directors
HELD ELECTRONICALLY
Thursday 7 May 2020 at 1000hrs
VIRTUAL MEETING

Item no. 2020/21/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
033	Thank you	To provide a Team thank you – above and beyond			1000 (5mins)
034	Apologies for absence Declarations of interest	Receive apologies & declarations of interest	Verbal	Chair	
035	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written	Chair	
036	Patient Story	To receive the patient story	Verbal	Medical Director	1005 (15mins)
037	Minutes of the previous meeting held on 2 April 2020	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1020 (5mins)
038	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
039	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1025 (5mins)
040	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1030 (5mins)
BOARD COMMITTEE ASSURANCE					
041	Chair's Report & Annual Report from Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1035 (5mins)
042	Chair's Report & Annual Report from Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1040 (5mins)
043	Chair's Report, Annual Report and Terms of Reference from Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1045 (5mins)
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					
044	Covid-19 – Trust response	For assurance	Written	Director of Operations	1050 (15mins)
045	Safer Nurse/Midwife Staffing Monthly Report	For assurance and to note any escalated risks	Written	Interim Director of Nursing and Midwifery	1105 (10mins)
046	Care Quality Commission Update	For assurance	Written	Interim Director of Nursing and Midwifery	1115 (10mins)
047	NHS Staff Survey 2019 Results & Action Plan	For assurance	Written	Director of Workforce &	1125 (10mins)

Item no. 2020/21/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
				Marketing	
048	Review of 2019/20 Flu Vaccination Campaign & Planning for the 2020/21 Campaign	For assurance	Written	Director of Workforce & Marketing	1135 (5mins)
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES					
049	Operational Performance Report period M12, 2019/20	For assurance –To note the latest performance measures	Written	Director of Operations	1140 (5mins)
050	Finance Report period M12, 2019/20	For assurance - To note the current status of the Trust's financial position	Written	Director of Finance	1145 (5mins)
BOARD GOVERNANCE					
051	Board Assurance Framework 2020/21	For assurance and approval	Written	Trust Secretary/ Executive Leads	1150 (5mins)
052	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1155 (5mins)
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
053	Corporate Objectives 2019/20 Annual Review and proposed Corporate Objectives 2020/21	For approval	Written	Trust Secretary/ Executive Leads	Consent
054	Trust Board Terms of Reference	For approval	Written	Trust Secretary	Consent
HOUSEKEEPING					
055	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1200 (5mins)

Date of next meeting

Board in Public: 2 July 2020

Meeting to end at 1205

1205 - 1215	***Questions raised by members of the public submitted in advance of the meeting.***	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Liverpool Women's

Meeting attendees' guidance using Microsoft Teams

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

Before the meeting

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

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

Microsoft Teams

- Arrive in good time to set up your laptop/tablet for the virtual meeting
- Switch mobile phone to silent
- Find the appointment and open
    - If you have been sent the appointment as a diary invite click on Calendar on the left hand column. Open appointment and click join.
      Alternatively click on the link within the emailed diary appointment 'Join Microsoft teams'
    - If you have been asked to join an **existing** TEAM then please open Microsoft Teams, Click on Teams on the left hand column. Click on the relevant team you want to open, then click on Meet Now.
- Four screens (participants) can be viewed at one time. Those speaking will be viewable automatically.
- Click Show Participants to see who has joined the call as only 4 screens can be viewed at one time.
- Mute your screen unless you need to speak to prevent background noise
    - Only the Chair and the person(s) presenting the paper should be unmuted
    - Remember to unmute when you wish to speak
- Show conversation: open this at start of the meeting.
    - This function should be used to communicate with the Chair and flag if you wish to make comment
- Open files within Microsoft teams
    - Within your team, click on Files – top of the page.
- Use headphones if preferred
- Camera on option
- Screen sharing
    - If you wish to share a live document from your desktop click on share and identify which open document you would like others to view
- Use multi electronic devices to support teams.
    - You might find using both mobile and laptops is useful. One for Microsoft teams and one for viewing papers

At the meeting

- 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)
- Consent agenda items, taken as read by members and the minutes will reflect recommendations from the paper. Comments can still be made on the papers if required.

Attendance

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

After the meeting

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

Standards & Obligations

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

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

Page 129 Handbook to the NHS Constitution 26th March 2013

Liverpool Women's NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held in public at 10.00am on 2 April 2020 Virtual Meeting

PRESENT

Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Mrs Michelle Turner	Director of Workforce & Marketing
Mrs Jenny Hannon	Director of Finance
Dr Andrew Loughney	Medical Director & Deputy Chief Executive
Ms Gaynor Hales	Interim Director of Nursing & Midwifery
Mr Gary Price	Director of Operations
Mr Phil Huggon	Non-Executive Director
Mr Tony Okotie	Non-Executive Director/SID
Dr Susan Milner	Non-Executive Director
Mr Ian Knight	Non-Executive Director
Mrs Tracy Ellery	Non-Executive Director
Prof Louise Kenny	Non-Executive Director

IN ATTENDANCE

Mr Mark Grimshaw	Trust Secretary
Mrs Mary McDonald	Public Governor

APOLOGIES:

Ms Jo Moore	Non-Executive Director

20/21/	
001	**Thank You** The Chair noted that considering the significant pressures that staff had been under since the COVID-19 outbreak, it was not appropriate to identify a small number of individuals or teams for specific thanks. Therefore, a video message would be recorded from the Chair and Chief Executive and circulated to all staff thanking them for the dedication, flexibility and skill shown over the previous month in response to the COVID-19 pandemic.
002	**Apologies** – as above **Declaration of Interests** – Ms Gaynor Hales noted that she was a Non-Executive Director at Merseycare NHS Foundation Trust.
003	**Meeting guidance notes** The Board received the meeting attendees' guidance notes which had been updated to reflect 'virtual meetings'.
004	**Minutes of previous meeting**

	The minutes of a Board of Directors meeting held on 6 February 2020 were agreed as a true and accurate record.
005	**Matters arising and action log.** There were no matters arising. The Board of Directors reviewed the Action Log and noted that there were no outstanding actions.
006	**Chair's Announcements** The Chair stated that the Board's thoughts and wishes were with Caron Lappin, Director of Nursing and Midwifery, as she recovered from illness. Ms Gaynor Hales was welcomed as Interim Director of Nursing and Midwifery. The Board's Nomination and Remuneration Committee had taken an out of meeting decision to support the CEO in making a timely interim appointment. This decision would be ratified at the next formal meeting of the Nomination and Remuneration Committee (virtual or otherwise). It was noted that due to the COVID-19 outbreak and the meeting being held virtually it was not possible for members of the public to be physically present, however as normal for meetings held in public the agenda and papers had been available on the Trust website and written questions invited which would be considered at the end of the meeting and responses published. In addition, Trust Governors had been invited to join the meeting as observers and Mrs Mary McDonald was present in this capacity. The Chair briefed the Board on events since the last meeting. Prior to the COVID-19 outbreak, the Chair had continued to meet and develop relationships with partnering and neighbouring Trusts. A Council of Governors meeting had been held on 13 February 2020 with a focus on the recent CQC inspection, operational performance, the annual plan and budget setting and findings from the Council of Governors effectiveness survey. A workshop session was held on the survey results and areas identified for further work included training, meeting formats and engagement opportunities. Post the COVID-19 outbreak, the Chair noted that the Trust had continued to hold key assurance meetings virtually. The Board noted their appreciation to the IT team for their dedication and hard work in facilitating this capability. In addition to scheduled Committee meetings, a fortnightly Non-Executive Director meeting had been established to receive briefings from the Executive Directors. The Chair asserted that it would be important to capture the lessons learned from virtual and remote working for when the organisation reverted to 'normal' working arrangements. This included focused meetings, concise reports and clear recommendations. The Chair stated the importance of maintaining a connection with the Council of Governors to ensure that they maintained their statutory responsibilities. Discussions had been held with the Chair, Senior Independent Director, Lead Governor and Trust Secretary regarding appropriate arrangements. It was planned to hold a virtual sub-group meeting in April 2020 and work was underway to map the key decisions required over the coming months. The Board noted the Chair's verbal update.
007	**Chief Executive's report** The Chief Executive presented a report which detailed local, regional and national developments. She briefed the Board on the content of the report and noted the following subjects in particular: • An outline of the Trust's COVID-19 response. It was highlighted that further detail was provided later in the agenda. • The Trust had responded to the CQC Inspection report with a factual accuracy check.

	The Director of Finance noted that the timescales relating to the Maternity Incentive Scheme – Year 3 had been impacted by the COVID-19 outbreak. Further information was awaited and this would continue to be monitored through the Trust's Committees. The Board of Directors: • Received and noted the Chief Executive's Report
008	**Chair's Reports from Quality Committee (QC) & Terms of Reference** Dr S Milner presented the Chair's Reports for the meetings of the Quality Committee held on 24 February 2020 and 23 March 2020. She briefed the Board on the content of the reports and noted that the March 2020 meeting had been the first Board Committee to be held virtually. The agenda had been re-focused to receive a detailed update on the quality implications of the COVID-19 outbreak. There was a recognition at the meeting that future agendas would be shaped with the acceptance that capacity would be limited whilst managing the COVID-19 outbreak. It was noted that the Committee Terms of Reference had been reviewed and were recommended for approval by the Board. The Board of Directors: • Received and noted the Chair's Reports from the Quality Committee meetings held on 24 February 2020 and 23 March 2020. • Approved the Quality Committee Terms of Reference
009	**Chair's Reports from Finance, Performance and Business Development Committee (FPBD) & Terms of Reference** Mr P Huggon presented the Chair's Reports for the meetings of the Finance, Performance and Business Development Committee held on 25 February 2020 and 24 March 2020. He briefed the Board on the content of the reports and noted that two key risks had been identified in the March 2020 meeting. These related to the implications on the COVID-19 outbreak on the neonatal build completion timescales and to the realisation of the emergency capital bid application. The Director of Finance noted that these issues would be discussed later in the meeting. With regard to the Board Assurance Framework, the Committee recommend for Board approval a) a new narrative for risk 2184 - EPR and b) the introduction of BAF risk 2335 - cyber security. It was noted that the Committee Terms of Reference had been reviewed and were recommended for approval by the Board. The Board of Directors: • Received and noted the Chair's Report from the Finance, Performance & Business Development Committee meeting held on 25 February 2020 and 24 March 2020. • Approved the Finance, Performance and Business Development Committee Terms of Reference
010	**Chair's Report from Audit Committee (AC) & Terms of Reference** Mrs Tracy Ellery presented the Chair's Report from a meeting of the Audit Committee held on 24 March 2020. She briefed the Board on the content of the report and noted in particular the encouraging assurance levels that had been provided for Ward Quality Spot checks undertaken by the internal auditor. The Board remarked upon the 'high' and 'substantial' assurances that had been received by the Gynaecology Emergency Department and Gynaecology Inpatients respectively and agreed to provide a written 'thank you' to the department.

	Action: For a written thank you to be provided to the Gynaecology Department following the outcomes of the Ward Quality Spot Check. Assurances had been provided to the Committee from the internal auditor that they were satisfied that the appropriate management actions were being taken to address the issues raised in the Cyber Security Review. The internal auditor had provided a 'substantial' rating in their draft 2019/20 audit opinion and the Committee had noted the need to potentially 're-phase' the 2020/21 internal audit plan in the context of COVID-19. A similar position was taken in relation to the anti-fraud 2020/21 work plan. The Trust's external auditor had confirmed that they were working closely with the finance team to progress the 2019/20 audit utilising remote working and technology. Whilst the government had announced a deferment to the Data Security and Protection Toolkit (DSPT) submission deadline, the Director of Finance noted that the Trust had submitted the toolkit in line with the existing deadline. It was noted that the Committee Terms of Reference had been reviewed and were recommended for approval by the Board. The Board of Directors: • Received and noted the Chair's Report from the Audit Committee meeting held on 24 March 2020. • Approved the Audit Committee Terms of Reference
011	**COVID-19 – Trust Response and Preparations** The Director of Operations reported that the Trust had enacted business continuity measures in response to the international COVID-19 (Coronavirus) pandemic in line with its responsibilities as a Category 1 responder under the Civil Contingencies Act. The response to the COVID-19 outbreak was generating a significant amount of information and guidance from various sources. Requests were also being made of the Trust to provide information to local, regional and national systems. The Trust had implemented a governance structure which was intended to ensure that there was a co-ordinated response to information being received and that was sufficiently agile for timely yet robust decision-making. The structure supported the Trust in managing the day-to-day demands whilst also remaining sighted on wider, strategic considerations. The Director of Operations provided assurance that key decisions were being taken with clinical and infection control input. To date, core services continued to operate at the usual standard. Specific operational support had been allocated to oversee the impact on normal activity of the organisation and to also commence planning for recovery. The Medical Director reported that the Trust was currently fit for purpose in terms of Personal Protective Equipment (PPE) provision to staff. Work was underway to ensure that this remained the case. Staff testing for COVID-19 had been limited to date in line with the national position. There was a recognition that testing was important for reassuring staff and it was noted that the Trust would respond as quickly as possible to give staff access to testing. The Chair queried whether testing would be for clinical staff only or for other staff groups. The Director of Workforce and Marketing stated that initially priority would be given to staff in clinical care areas. The Medical Director noted that an effective response to the COVID-19 pandemic would require strong partnership working across the region. The Trust had made 'step down' beds available for patients from Liverpool University Hospitals NHS Foundation Trust (LUHFT) to free up additional

	critical care capacity at LUHFT hospitals. Work was also progressing to develop a 'buddy system' for obstetric services across the region to ensure that support was available if required. The Trust would be working with Southport & Ormskirk Hospitals NHS Trust in this way. Discussions were also being held with other partner organisations to maximise critical care capacity and ensure robust core service delivery throughout Cheshire and Merseyside. A discussion was held on the risks posed by the COVID-19 pandemic. The Medical Director asserted that the most significant risk was to maintain business as usual standards as focus and capacity was given to responding to COVID-19. The Chair noted that it would be important to identify the key mitigations and controls and for the Board to seek assurances that these remained sufficiently robust. Further thought was being given to how best to reflect issues relating to COVID-19 on the Board Assurance Framework and this would be discussed further by the Board's committees. Mr P Huggon asked what measures the Trust had taken to ensure that staff well-being was maintained. The Director of Workforce and Marketing acknowledged that there was a heightened level of anxiety within the various staff groups. The Trust's mental health first aiders had been encouraged to be pro-active with staff and there had been increased sign-posting via internal communication channels. The catering offer on site had been extended for staff and opening hours made more flexible. Opportunities for staff to roll forward or sell annual leave had also been made available. In line with national initiatives, the Trust had made car parking free for staff during April, May and June 2020. The Chief Executive noted that there was also a role for the Trust in ensuring that clear messages were being communicated to patients and their families via social media. The Chair noted that the COVID-19 pandemic would potentially result in the need for difficult decisions to be taken in the provision of care and questioned whether ethics was a consideration in the current decision-making structure. The Medical Director reported that ethical issues were subject to discussion at the Clinical Advisory Group but noted that an independent view, possibly on a regional footprint would be helpful. Potential models were under consideration and progress would be reported to the Board when appropriate. The Chief Executive provided assurance that robust leadership arrangements were in place. The Executive Team had moved to a seven-day on-site presence utilising a rota with usual on-call arrangements continuing. Moving forward, discussions would progress with the Executive Team to identify a model for the effective management of COVID-19 and the 'day-to-day' business. The Medical Director added that resilience rotas had been implemented across the Trust and action taken to identify the minimum rota requirements for maintain core services safely. Mr I Knight queried whether volunteers were still present at the Trust. Due to restrictions on non-essential attendance, volunteers were currently not on-site. A link was being maintained and the volunteer workforce would be utilised when appropriate and safe. Some non-clinical staff had been re-purposed to undertake 'floor walking' activities to disseminate and collate key messages to and from the front line. The Board of Directors: • Noted the update for information and assurance.
012	**Safer Nurse / Midwife Staffing Monthly** The Interim Director of Nursing & Midwifery presented a report which detailed Ward Staffing levels across all inpatient clinical areas during January and February 2020. She briefed the Board on the content of the reports and noted the positive fill rates and progress made in relation to recruitment, particularly in theatres. It was reported that whilst the need to submit safe staffing positions had been suspended, the Trust would continue to collect safe staffing data and report to the Board.

	The report provided a 'forward look' in terms of the impact of COVID-19 on staffing rates. Sickness had increased during March 2020 although some staff were now returning from periods of self-isolation. Work was underway to explore different models of utilising nurse staffing to maintain core services. The Medical Director noted that a similar position had been experienced with medical staffing. A twice weekly update on medical absences and expected times of return to work was being provided to the Medical Director for oversight. The Director of Workforce & Marketing commented that COVID-19 related absences were at 8% with all other sickness at 6%. The Trust was in a more favourable position than other trusts in the region. The possibility of the medical and nursing workforce being supplemented by the return-to-work of recently retired doctors and nurses was being managed centrally. The Trust would remain cognisant of the support these staff would require should they be allocated to the organisation. Prof L Kenny noted that the University of Liverpool was able to graduate fifth year medical students earlier than scheduled. Most students had been placed in acute adult trusts and would help to relieve staffing pressures. Nursing students had also been encouraged to remain in clinical placements. The exceptions to this were students that were complying with Public Health England guidance. The Board of Directors: • Received and noted the Safer Nurse / Midwife Staffing Monthly Report.
013	**2020/21 Operational Plan and Budget Update** The Director of Finance provided a verbal update on the development of the 2020/21 Operational Plan and Budget. It was noted that the requirement to submit operational plans to NHSI/E had been suspended due to the COVID-19 pandemic. The Trust would receive block payments for services based on 2019/20 figures, with monthly adjustments to reflect expenditure requirements. Guidance had been received on 28 March 2020 from NHSI/E in relation to 'Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic'. There were several implications from this guidance which included extensions to the annual accounts and audit processes for 2019/20. The Director of Finance noted that whilst there had been a relaxation of reporting requirements, it was vital that the Trust continued to recognise and maintain its fiduciary duties in the management of public funds. It was explained that the draft Operational Plan signed off by the Board on 5 March 2020 would form a baseline from which to monitor spend and particularly expenditure in relation to the COVID-19 response. Whilst there was no expectation that the Trust would continue to deliver on its CIP programme, it was the intention to continue to deliver on projects should they not adversely impact on resources to deliver care. The Trust had not received a capital allocation to date and was intending to utilise the draft 2020/21 plan as a guide. In relation to the emergency capital bid, it was likely that capital requests directly in response to the COVID-19 pandemic would receive priority. The Trust would need to maintain a watching brief on this position. It was reported that construction workers remained on site to continue work on the Neonatal build which was close to completion. They were using their own direct entrance to the site and the intention was to continue with the project unless doing so would add risk to patients and/or staff, or national guidance prevented this. Advice on this issue had been taken from the Director of

	Estates and Facilities with support from the neonatal team. This position would be kept under review through the Neonatal Programme Board. The Director of Finance informed the Board that the majority of the reporting requirements in relation to the 10 CNST incentive safety actions had been paused until September 2020. The importance however of delivering safe care in the meantime was noted along with the continuation of other standard reporting in maternity. It was also noted that the 10% premium which made up the incentive would not be collected in 20/21. An additional risk of attempts at fraud and reporting error was noted as a result of the COVID-19 situation. Robust oversight would be maintained on these issues. Whilst a number of issues were still evolving, the Director of Finance reported that there were no major concerns regarding liquidity at the current time. Additional reports would be presented at the FPBD Committee for assurance purposes. The Board of Directors: • Received and noted the verbal update on the 2020/21 Operational Plan and Budget
014	Operational Performance Report Month 11 2019/20 The Director of Operations presented the Operational Performance Report for Month 11 2019/20. He briefed the Board on the content of the report and provided an overview of performance against key national standards as detailed at s2 of the report. Attention was drawn to the improved performance against the 18-week Referral to Treatment target and it was noted that there had been three months without a 52 week breach. Due to the COVID-19 pandemic, the requirement to submit performance information had been suspended. The Trust intended to continue to capture and monitor performance. The Chair stated that the ability to continue to monitor performance would be vital in ensuring that 'business as usual' standards did not deteriorate. The Director of Operations noted that it was likely that new access targets would be put into place once the COVID-19 situation was under control. The Board of Directors: • Received and noted the Month 11 Operational Performance Report.
015	Financial Report & Dashboard Month 11, 2019/20 The Director of Finance presented the Finance Report and Financial Dashboard for Month 11, 2019/20. She briefed the Board on the content of the report and advised that at Month 11 the Trust was reporting a deficit of £0.4m against a deficit budget of £0.4m. The Trust was forecasting delivery of the breakeven control total, after £4.6m of central funding. The Board of Directors: • Received and noted the Month 11 Financial Performance Report
016	Well-Led Framework Self-Assessment The Trust Secretary noted that NHSI/E encouraged all Foundations Trusts to undertake a development review of leadership and governance against the well-led framework approximately every three years. The most recent external review was carried out in 2016/17 by Deloitte LLP with outcomes reported to Board in May 2017. It was therefore timely for the Trust to undertake a review. A self-review process had been undertaken and an evidence template completed with input from both Executive and Non-Executive Directors. This had produced RAG ratings against the eight Key

	Lines of Enquiry (KLOEs) within the framework and a series of improvement actions. A number of high level findings were outlined and it was suggested that an improvement plan be developed and reviewed alongside a procurement exercise for an external review. The timeline for this review would need to be considered within the context of the COVID-19 outbreak. The Board of Directors: • Approved the Well-Led Self-Assessment template • Agreed to the development of an improvement plan • Agreed to commission an external Well-Led review to be undertaken when appropriate.
017	**Review of Risk Management Strategy 2020/21** The Board received the updated Risk Management Strategy noting that it had also been received by the Quality Committee and Audit Committee. The Board noted the recent (2018/19) assurance provided from the MIAA Internal Audit review of the risk management process, which had provided substantial assurance that the core control mechanisms were in place to manage the risk management process. The Board of Directors: • Approved the Risk Management Strategy 2020/21
018	**Board Assurance Framework** The Trust Secretary presented the Board Assurance Framework 2019/20. He briefed the Board on the content of the report noting which BAF risks had met their target score during the year and which risks had not met the target score. Since the last report to the Trust Board, two new risks had been identified, developed and recommended for approval by Committees of the Board. These related to: • 2335 - Condition: Major and sustained failure of essential IT systems due to a cyber-attack. • 2337 - Condition: The Trusts current clinical records system (paper and Electronic) are sub-optimal (This was a re-framed version of an existing risk relating to the delivery of the EPR). The Board was requested to review these risks and approve their inclusion onto the BAF. A discussion was held with regards to the COVID-19 pandemic and the most effective way to reflect the attendant risks on the BAF. There was acknowledgement that developing a new specific BAF risk would enable clear visibility of the issue, but consideration would need to be given to the interdependencies with the existing BAF risks. The Trust Secretary noted that further thought was required and draft versions would be considered by the Board Committees later in the month. The Board of Directors: • Received the Board Assurance Framework • Approved the new risks in relation to EPR and Cyber-attacks for inclusion onto the BAF.
019	**Proposed Risk Appetite Statement 2020-21** The Trust Secretary explained that the Board's Committees (QC and FPBD) had met and agreed the parts of the statement for which they had oversight and assurance responsibility. The Putting People First (PPF) Committee had not met in March 2020 and therefore the Director of Workforce and Marketing undertook a virtual approval process of committee members and approval from PPF was gained. The Board were asked to review the statement in its entirety and provide approval.

	The Board of Directors: • Approved the Risk Appetite Statement for 2020-21.
020	**Board Terms of Reference** The Trust Secretary explained that the Trust did not currently have a Terms of Reference for the Board. Whilst this was not a requirement, it was considered good practice and had been highlighted as a development point following the recently completed NHS Improvement Well-Led Framework Self-Assessment. The Board was asked to agree to the principle of adopting a Board Terms of Reference and to provide comment on a draft provided as an appendix to the report. The Board of Directors: • Approved the principle of adopting a Board Terms of Reference • Agreed to provide comments outside of the meeting on a draft Board Terms of Reference ahead of its ratification at a future meeting.
021	**Review of risk impacts of items discussed** The Board noted that the following risks had been discussed during the meeting: • Development of a BAF risk relating to COVID-19 • Increased need to reassure and provide information to patients as a result of the COVID-19 pandemic • Impact on the realisation of emergency capital funding in the context of the COVID-19 pandemic • Heightened risk of fraud and financial reporting errors as a result of the COVID-19 pandemic.
022	**Any other business & Review of meeting** It was noted that the public questions section would be recorded and uploaded to the Trust website. Mrs Mary McDonald (public governor) stated that it had been an informative meeting. Staff well-being in the context of the COVID-19 pandemic had been a concern but assurance had been provided in the meeting. She highlighted the importance of maintaining standards and 'business as usual'. **Date of next meeting** The Chair reported that the next meeting of the Board of Directors in public would be held on 7 May 2020.

TRUST BOARD
7 May 2020
Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
2 April 2020	20/21/10	For a written thank you to be provided to the Gynaecology Department following the outcomes of the Ward Quality Spot Check.	Director of Workforce & Marketing	Completed	Letter drafted and sent to the Gynaecology Department

	Completed actions: concluded before the next board or on the agenda of the next Board
	Progress paused due to Covid-19 pandemic
	In Progress - either at Committee stage or awaiting presentation at Board or Board workshop
	in progress - missed original deadlines agreed at Board

Agenda Item	2019/069

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Chief Executive Report**
DATE OF MEETING:	Thursday, 07 May 2020
ACTION REQUIRED	**For Noting**
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	Mark Grimshaw, Trust Secretary
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……..* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……..* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for*

	sustainable integrated care or quality service provision …….. ☒ ***6.*** *Ineffective understanding and learning following significant events……..* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……..* ☒ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☒ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services..* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes,* ☐ *promotes a good quality of life and is based on the best available evidence.* ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity* ☐ *and respect.* ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the* ☐ *organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ***ALL DOMAINS*** ☒

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution	☒	**4.** NHS Constitution	☒
	2. Operational Plan	☒	**5.** Equality and Diversity	☒
	3. NHS Compliance	☒	***6.*** Other: **Click here to enter text.**	

FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: *(eg: The Board/Committee is asked to:-….)*	***Board is asked to note the content of the report.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable
	Date of meeting	

Executive Summary

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

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

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

Report

SECTION A - Internal

COVID-19 Response – The Trust continues to respond to the COVID-19 pandemic under the Civil Contingencies Act and our focus remains on how best to protect our patients, staff and visitors at this very difficult time. I am very grateful to all of our staff for the tremendous amount of work they have been doing, and will continue to do, to help contain the spread and provide high quality services.

We realise that this is a worrying time for patients and their families. Therefore, we have developed a Covid-19 Information Hub on the Trust website to provide updates with the latest advice and guidance as well as details of any restrictions we have in place at the hospital. This section of the website is updated on a regular basis and I would encourage anyone who is seeking information about the Trust and its services at this difficult time to access this information as a first port-of-call.

The Trust has had to make some changes to its services because of the Covid-19 pandemic. One of the most recent of these changes has been the temporary suspension of home birth services from 21st April 2020. Liverpool Women's is a strong advocate for supporting every individual woman's choice of birth. However, because of the current impact of Covid-19 on the wider health system, we feel it would be unsafe to continue with our homebirth service at this time which could also put additional pressure on our local NHS partner organisations if our Homebirth Team required their support in an emergency. This decision has also been made collaboratively with the Local Maternity System across Cheshire and Merseyside, resulting in most providers in the region taking the same course of action as Liverpool Women's.

Whilst we hope that we will be able to resume normal services soon, there is no clear timeline for this and the current suspension will remain in place until further notice. However, we will be reviewing the situation on a weekly basis and should there be any changes or clearer indications of timescales for re-introducing the service, we will update women, families and staff. All other maternity services within the Trust remain unchanged.

Where any changes to services are being made as a result of the Covid-19 pandemic, the Care Quality Commission are being kept fully informed.

The Trust has recognised that the Covid-19 presents some new risks and heightens several pre-existing risks. There is a proposal later in the agenda for the Board to agree the adoption of a new Board Assurance Framework risk relating to Covid-19. Despite the situation presenting risks and challenges, a huge amount of learning will also be gained from the current crisis that can be converted into actions to strengthen the Trust's agility, resilience, efficiency and effectiveness for the future. The Trust is embarking on a piece of work to capture this learning and evaluate how to maximise it during a recovery phase.

Care Quality Commission (CQC) - As Board members will be aware, the CQC visited the Trust on two occasions in recent months, firstly, to carry out an unannounced core services inspection in December 2019 and, more recently, to complete a Well-Led inspection which took place between 14-16 January 2020.

The report was published on the CQC website on 24 April 2020 and the CQC has once again rated Liverpool Women's NHS Foundation Trust as 'good'. The report highlights that the Trust demonstrates a patient centred approach with clear examples of compassion, kindness, and support for privacy and dignity.

The core services inspection carried out in December 2019 resulted in a Warning Notice being issued by the CQC in relation to identified weaknesses in Medicines Management arrangements. The Trust submitted a detailed response to the CQC within the required timescale outlining the immediate and subsequent actions taken to address those failings together with detail of how ongoing assurance would be tested. Further detail on this can be found later in the agenda together with more detail on the rest of the CQC report.

You can read the full report here: https://www.cqc.org.uk/sites/default/files/new_reports/AAAK0639.pdf

Operational Plan 2020/21: The Trust is usually required to submit an operational plan to NHS Improvement/England (NHSI/E) for the forthcoming financial year in April. Due to the challenges posed by the Covid-19 pandemic, this requirement has been removed. The Trust will be utilising a draft plan, agreed by the Board in March 2020, to monitor its financial and operational performance. Assurance on this process is scheduled for reporting through the Trust's governance structures this month.

Pause in reporting procedure regarding the maternity incentive scheme – NHS Resolution has informed the Trust that in recognition of the current pressure on the NHS and maternity services, the majority of reporting requirements relating to demonstrating achievement of the maternity incentive scheme 10 safety actions are paused with immediate effect until Monday 31 August 2020. This will be kept under review. Trusts have been asked to continue to apply the principles of the 10 safety actions, given that the aim of the maternity incentive scheme is to support the delivery of safer maternity care. The Trust is continuing to monitor delivery on the safety actions. A challenge has bene identified regarding the safety actions relating to training but workarounds are being considered.

It has also been agreed that the 10% uplift to the Clinical Negligence Scheme for Trusts (CNST) for the maternity incentive scheme will not be collected from April 2020 for the year 2020/2021. The remainder of the notified CNST contribution will be collected as normal.

SECTION B – Local

Liverpool Health Partners Bulletin – The Trust received the bulletin (attached in full in appendix 1), which reflects Liverpool Health Partners' response to the impact of COVID-19 in the region and nationally, and how LHP is supporting Partners to fight the pandemic, particularly through directing the majority of research to COVID-19. Although LHP are prioritising COVID-19-based endeavours, LHP's Chief Executive Officer, Dr Dawn Lawson has assured partners and stakeholders that LHP remains fully operational throughout this current crisis.

SECTION C

Regulatory changes – Covid-19 – NHSI/E wrote to trusts at the end of March 2020 on action that had been taken to reduce the burden and release capacity at NHS providers and commissioners to manage the COVID-19 pandemic. The key highlights of this were as follows:

- The implementation of International Financial Reporting Standard (IFRS) 16 is being deferred until 2021/22.
- Draft accounts due on 27 April, but provider organisations can extend this to 11 May if they wish.
- There are associated amendments to key data for providers, and agreement of balances process dates.
- Audited accounts are now due on 25 June 2020.
- Quality accounts: The Department of Health and Social Care (DHSC) is working to amend Regulations which specify these arrangements. It is not expected that providers will be subject to the 30 June 2020 deadline.
- Quality reports for NHS foundation trusts: there will no longer be a requirement to include a quality report in the annual report
- Auditor assurance work on quality accounts and quality reports should cease for 2019/20.
- Provider organisations will no longer be required to submit any hard copy documents to NHS Improvement for the annual report and accounts.
- NHSI/E are working with the DHSC and HM Treasury on potential streamlining of annual report requirements.

Dear Colleague,

LHP SPARK is more necessary now than ever with the challenges arising in relation to Our newsletter this month reflects Liverpool Health Partners' response to the impact of COVID-19 in the region and nationally, and how LHP is supporting Partners to fight the pandemic, particularly through directing the majority of research to COVID-19 (see below). Although we are prioritising COVID-19-based endeavours, LHP's Chief Executive Officer, Dr Dawn Lawson would like to assure partners and stakeholders that LHP remains fully operational throughout this current crisis.

Board meeting 27 March

The Board met last month via videoconference and supported, among routine business and governance items, a number of proposals to develop LHP including: the proposed business and financial plan for 2020-21 and the concept of the Liverpool Innovation System Model.

The year ahead will see an increasing focus on mental health research and operationalisation of its successful Civic Data Cooperative application. LHP will also develop, in conjunction with Partners, its education and training offer to member organisations. There will be stronger engagement with primary care via the appointment of a senior clinician, and progression of the proposed Liverpool System Innovation Model. This model will align innovation assets across the City so that there is one clear approach for pulling innovation through across the City. This will be supported by, among other things, the appointment of an Innovation Manager working in conjunction with the Innovation Agency.

Finally, all the above will be supported by a strengthened LHP communications function.

LHP SPARK: fully supporting our members to respond to the COVID19 challenge

LHP SPARK is more necessary now than ever with the challenges arising in relation to Coronavirus and the effect this is having on the conduct of research across LHP sites. This is a critical time for infection research across the city with a growing number of national studies and new local studies in development. Our response to the crisis includes the following:

Setting up COVID research

We are working closely with the NIHR Clinical Research Network to prioritise studies and to track capacity across the system.

We currently have:

- 5 NIHR UPH (Urgent Public Health) Studies recruiting across 6 LHP hospital sites:
    -
    - RECOVERY trial: Randomised Evaluation of COVID-19 Therapy - open at LUHFT (Royal and Aintree), Walton Centre and LWH, with Alder Hey in set- up.
    - CCP-Severe Emerging Infection: Clinical Characterisation Protocol for Severe Emerging Infection - open at LUHFT (Royal and Aintree), Alder Hey and LHCH, with CCC in set up.
    - UKOSS: Maternal and Perinatal Outcomes of Pandemic Influenza in Pregnancy - open at LWH.
    - Coronavirus infection in immunosuppressed children: open at Alder Hey
    - The PRIEST study: Pandemic Respiratory Infection Emergency System Triage – open at LUHFT (Aintree open; Royal in set-up), with Alder Hey in set-up.

- Further 5 NIHR UPH (Urgent Public Health) Studies in set-up across LHP partners:
    -
    - REMAP-CAP: Randomized, Embedded, Multifactorial, Adaptive Platform trial for Community-Acquired Pneumonia – in set-up at LUHFT (Royal and Aintree) and LHCH.
    - A Phase 3 Randomised study to evaluate the Safety and Anti-Viral activity of Remdesivir (GS-5734) in participants with severe COVID-19: in set-up LUHFT (Royal) and Alder Hey.
    - 5774 Safety & Antiviral Activity of Remdesivir for moderate COVID-19: in set- up at LUHFT (Royal) and Alder Hey.
    - RECOVERY: Supportive Care - in set-up at LUHFT (Royal).
    - GenOMICC: Genetics of susceptibility and mortality in critical care – in set-up at Walton Centre and LHCH.

- 2 COVID-19 studies awaiting NIHR UPH (Urgent Public Health) status open to recruitment across LHP partners:
    -
    - SAFER: SARS-CoV-2 Acquisition in Frontline Health Care Workers – Evaluation to Inform Response – open at LUHFT (Royal) and CCC (PIC site).
    - FASTER: Facilitating A SARS CoV-2 TEst for Rapid triage – open at LUHFT (Royal and Aintree)

Supporting COVID grants

The LHP SPARK Grant Application Team are supporting new rapid responses to COVID funding and providing continuing support to pre-existing grant applications, totalling 16 studies.

Providing COVID guidance

LHP SPARK have also created a resources hub for all information about COVID research, regulatory and governance issues, funder guidance and information about information governance/ data.

Follow us on Twitter for updates and see our webpages for further information.

LHP Programmes: Impact of COVID-19

All our programmes are becoming involved in a range of COVID-19 workstreams. This has meant partial re-deployment of some of our Programme Managers to assist with LHP SPARK activities and to support other areas outside of their usual day-to-day work. We are also in discussions with NHS partners regarding support to their Trusts. A full update on work within our programmes can be found on the research update pages of our website and in summary:

Infection

Liverpool School of Tropical Medicine, the University of Liverpool and the NHS, represented by Liverpool Health Partners, have united to redirect the majority of Liverpool's research efforts to COVID-19. The research programmes are designed to have immediate benefits for public health. This programme is supported by approximately £1 million in pump priming from LSTM and UoL; galvanising the efforts of over 200 researchers, underpinned by equipment and laboratory space across the Liverpool City Region.

Please click here to see our programmes update in full

Cardiovascular

Our Cardiovascular (CVD) theme is assessing the impact of COVID-19 on CVD issues and re-directing priorities to respond to the crisis. In the meantime, our Liverpool Centre for Cardiovascular Science Research Group continues to meet virtually, receiving two presentations from PhD students on CVD research.

Please click here to see our programmes update in full

Starting Well

The Starting Well programme team has highlighted within its key priority programmes those which have the potential to be aligned to COVID-19 related research. In the first instance, we will be writing out to research leads to provide an update on this progress and to detail next steps. We will be progressing with those programmes where we can add most value at this time and will be

looking to schedule these initial meetings (virtually) in the coming weeks.

Please click here to see our programmes update in full

Informatics

An interim LHP Informatics Leadership Group will hold its first virtual meeting planned for 20 April. A wider group of stakeholders will be contacted following this meeting to bring in all LHP Partners into developments around the Civic Data Cooperative

Please click here to see our programmes update in full

Cancer

In support of the One Liverpool Covid19 pandemic response, the LHP cancer programme led by Professor Andy Pettitt, is working on the development of a portfolio of emerging cancer/Covid19 research projects bringing together multidisciplinary teams for biomedical (fundamental, translational, clinical) and psychology/social science based studies. Please contact Matina Tsalavouta, LHP Cancer Programme Manager for further information.

Please click here to see our programmes update in full

Neuroscience

Professor Conor Mallucci has now joined LHP as Programme Director for LHP's Neuroscience and Mental Health programme. Starting Well, CVD and Cancer programmes have already begin supporting Conor in establishing the programme, including a new collaborative with the Cancer team in Neuro-oncology (both adult and paediatric), which has clear plans and vision to develop research activity and capacity in this area for the region.

Please click here to see our programmes update in full

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Quality Committee meeting held 20 April 2020

1. **Was the quorate met?** Yes (meeting was held virtually)

2. **Agenda items covered**
   - ~ **Subcommittee Chairs reports**: The Committee received and noted the Chair's report and approved the Terms of Reference from the Effectiveness Senate and Safety Senate. The Committee also received and noted the Chairs report from the Corporate Risk Committee and the Hospital Safeguarding Board.
   - ~ **Covid-19 Update:** The Committee received an in-depth position update with regards to the planning and management of patient services in relation to coronavirus and potential impact on quality. The Committee noted the Trust decision to maintain internal monitoring despite a national pause in the requirement to provide external monitoring. It also noted that currently wards are safely staffed. The Committee was assured by active surveillance measures of all patients that have had a cancelled operation to prevent causing harm. The regional approach to Homebirth options was also noted and acknowledged that the safest option would be to attend hospital at this time.
   - ~ **Board Assurance Framework Quality Related Risks**: The Committee reviewed the Quality related BAF risks and noted the inclusion of the approved EPR risk and the inclusion of the new overarching Covid-19 risk. Further work to map Covid-19 against the existing BAF risks would be undertaken following Board approval of the overarching risk narrative.
   - ~ **Quality and Regulatory Update:** The Committee noted that the Care Quality Commission (CQC) had completed the final inspection report and would publish Trust results on 21 April 2020. It was confirmed that work against the CQC action plans would continue to ensure patient safety and best practice is achieved. Particular attention was drawn to the Warning Notice that had been received from the CQC regarding Medicines Management. The actions that had been put into place to respond to the Warning Notice and ensure patient safety continued. Work was progressing to ensure that robust assurance could be provided that the updated processes had been fully embedded.
   - ~ **Corporate Objectives 2020/21:** The Committee noted a revised set of 2020/21 corporate objectives since the last meeting and approved a review at 3 months.
   - ~ **Quality Strategy 2020/25 Update:** The Committee noted the ongoing work to develop the Quality Strategy and the development of a Quality Improvement Strategy as part of this work. The Committee also received a verbal update with regards to the Quarter 4 position against the Quality Strategy.
   - ~ **Monthly Quality Performance Review M12 2019/20:** The Committee received an update on Operational Performance at Month 12 2019/20 and noted the increase of staff sickness and cancellations of surgery as expected due to the impact of Covid-19. It was noted that the Trust was working collaboratively within the region, including Cancer Alliance, CCGs and GP's to provide support, advice and guidance to maintain patient care.
   - ~ **Clinical Negligence Scheme for Trusts (CNST) Assurance Report:** The Committee noted that NHS Resolution had confirmed a pause in reporting against the 10 safety standards until 21 August 2020 however advised that trusts should continue to internally monitor as much as possible.
   - ~ **Contract Quality Schedule Assurance Report Q4 2019/20:** The Committee noted that this is a new addition to the Committee's workplan to provide assurance of work undertaken to achieve targets set within the quality contract agreed with the CCG.
   - ~ **Serious Incidents & Learning Report Q4 2019/20:** The Committee received the report and was assured by the SI process undertaken.

NHS

- ~ **Clinical Audit Work Programme 2020/21:** The Medical Director requested a further review of the work programme to ensure that it was deliverable within the context of Covid-19 and that the approach was aligned with the Trust's developing model for Quality Improvement. The Committee agreed to receive a revised version to approve at its next meeting.
- ~ **Quality Committee Effectiveness Annual Review:** The Committee approved the committee annual review as a good reflection of work undertaken during the period 2020/21.

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

No changes to existing risks were identified as a result of business conducted during the meeting. The new narrative for the Covid-19 risk was noted.

4. **Escalation report to the Board on Performance Measures**

The Committee highlighted continued potential impact on performance measures going forward in response to the COVID-19 pandemic.

5. **Issues to highlight to Board**

- ~ **Safeguarding Children and Adults**: The Committee noted the Safeguarding team had provided staff with extra guidance in relation to Making Every Contact Count (MECC) and increased routine enquiry to include all patients in response to the national rise of domestic violence events during the Covid-19 pandemic. The Committee challenged any further action to be undertaken and requested close monitoring of the position.

6. **Action required by Board**

The Committee recommend to the Board:

- ~ Approval of the corporate objectives 2020/21 against the key strategic aims for which this Committee is responsible
- ~ Approval of the Committee Effectiveness Annual review (enclosed)

Susan Milner
Chair of Quality Committee
20 April 2020

Quality Committee Annual Report 2019/20

Quality Committee

The Quality Committee is responsible for receiving assurance that the Trust has in place effective governance systems, risk management and quality improvement arrangements, and providing assurance to the Board of Directors that this is achieved as required by the organisation.

In discharging these duties, the Committee is responsible for:

Strategy and Performance

a) Oversee the development and implementation of the Quality Strategy with a clear focus on upholding the tenants of quality (Governance, safety, patient experience and clinical effectiveness).

b) Ensure that the Quality Strategy and performance are consistent with the Trust's; Vision and strategic objectives and oversee any initiatives undertaken by the Trust that relates to the development and implementation of the Quality Strategy.

c) Review trends in patient safety, experience and outcomes (effectiveness) to provide assurance to the Board on performance and commission 'deep dives' as appropriate.

d) To receive assurance that action plans arising from in-patient, out-patient and other care related surveys are being undertaken and make recommendations to the Board as appropriate.

e) Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery.

Governance

f) Oversee the effectiveness of the clinical systems developed and implemented to ensure they maintain compliance with the Care Quality Commission's Fundamental Standards in relation to Quality, Safety, experience and effectiveness.

g) Obtain assurance of the Trust's ongoing compliance with the Care Quality Commission registration.

h) Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that risks to the strategic objectives relating to quality and safety are being managed and facilitate the completion of the Annual Governance Statement at year end.

i) Obtain assurance that the Trust is compliant with guidance from NICE (through receipt of an Annual Report) and other related bodies.

j) Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from NHSI, the Care Quality Commission, the Health and Safety Executive and other external assessors.

k) Receive the annual clinical audit programme and provide assurance to the Board that clinical audit supports the Trust to provide safe and clinically effective patient care and obtain assurance that there is delivery against agreed annual clinical audit programme.

l) Implement and monitor the process for the production of the Trust's year end Quality Report before it is presented to the Trust Audit Committee and Board for formal approval.

m) Undertake an annual review of the Quality and Risk Management Strategies to ensure that they reflect all required priorities.

n) To have oversight of the Committees performance measures to ensure they are appropriate and provide assurance of compliance and escalate exceptions to Trust Board.

o) To review the proposed internal audit plan for all functions areas within the Committees remit e.g. Clinical Audit, Safety, Experience and Effectiveness.

p) Review the Trust's Research and Development Strategy and Innovation Strategy prior to their recommendation it to the Board of Directors.

q) Approving the terms of reference and memberships of its subordinate committees.

Overall

r) To approve any matters that, due to time constraints, could not be approved by the Board within the scope of the Committees areas of responsibility.

s) Referring relevant matters for consideration to other Board Committees as appropriate.
t) Considering relevant matters delegated or referred to it by the Board of Directors or referred by any of the Board Committees.
u) Escalating matters as appropriate to the Board of Directors.

This remit is achieved through the Committee being appropriately constituted and complying with the duties delegated by the Board of Directors through its terms of reference.

Constitution

The Quality Committee is accountable to the Board of Directors. Membership during the year comprised:

- Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- Medical Director
- Director of Nursing and Midwifery
- Director of Finance
- Director of Workforce and Marketing
- Director of Operations
- Deputy Director of Nursing and Midwifery
- Head of Governance
- Committee Chairs of the Safe, Experience and Effectiveness Senates

Meetings were also attended by other executives and senior management staff as appropriate.

The Committee met in accordance with the frequency laid out in its terms of reference. Ten meetings were held during the financial year 2019/20 to reflect the challenges faced by the Trust.

Members are able to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference.

The Terms of Reference requires that all members of the committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2019/20 together with the names of senior management who were invited to attend during the year. The majority of members attended 75% or more of the meetings during 2019/20.

The Terms of Reference of the Committee were reviewed in April 2019 in preparation for 2019/20 and further amended in September 2019.

Key Achievements

Significant clinical and governance matters were adequately discussed with appropriate regard to risk, generating appropriate actions which were duly followed up. Key achievements are noted below:

Board Assurance Framework (BAF)
The Committee regularly reviewed the Board Assurance Framework risks assigned in line with the business cycle of activities. The Committee held discussions over the rating of specific risks attributable to the Committee noting that they were being managed appropriately. The Committee reported all changes to the BAF at the next following Board of Directors meeting for approval.

Review of Risk Management Strategy
The Committee reviewed and approved the Risk Management Strategy of the Trust noting that MIAA had undertaken an Internal Audit review of the Risk Management process during 2018/19, which had provided substantial assurance on its effectiveness.

Review of Risk Appetite Statement 2020/21

The Committee performed a review of the Risk Appetite Statements for 2020/21 that related to the Committees sphere of responsibility: to deliver safe services; to participate in high quality research and to deliver the most effective outcomes; and to deliver the best possible experience for patients and staff. The Committee reviewed the risk appetite for each objective and agreed that for 'Safe Services,' 'Effective Outcomes' and 'Patient Experience' the level of risk appetite was appropriate and would not change from the risk appetite in 2019/20.

Quality Strategy 2017/20, Quality Strategy 2020/25 & Annual Quality Report 2019/20

The Quality Strategy, in conjunction with the BAF and Risk Management Strategy, form the foundation of the Quality Governance requirements of the Trust. The Committee received quarterly updates against the Quality Strategy 2017/20 on the Trust's performance in delivery of the strategy. The Committee also supported development of the Quality Strategy for 2020/25.

One of the requirements of the Committee is to approve and recommend to the Audit Committee and Board of Directors a Quality Report each financial year end. In the year under review the Committee received and approved the Trust's Quality Report 2018/19. This forms part of a suite of reports submitted to the regulator and Parliament. The requirements for the 2019/20 Quality Report have been amended with clarity awaited at the time of writing. It remains the intention of the Trust to produce a 2019/20 Quality Report which will be considered in due course by the Committee.

Mortality Strategies & Mortality Reporting

The Committee received an annual progress update against the adult mortality strategy and the perinatal mortality strategy at the meeting of 23 April 2019 and thereafter quarterly Adult Mortality & Perinatal reports had been received and noted by the Committee. It was noted that there was not a requirement to annually review the strategies and it was agreed to amend the business cycle to reflect this. The Committee would continue to receive the quarterly reports. The Mortality reports are available via the trust's public facing website.

Monthly Quality Performance Review 2019/20

The Committee continued to receive a monthly performance reports against the Quality Committee agreed indicators. The Serious Incidents reported at the beginning of 2018 relating to data quality concerns for RTT and Cancer continued to take high priority in terms of reporting Trust performance. The Committee had been assured throughout the reporting period that appropriate actions had been taken to address patient safety and experience and to improve performance.

Quarterly Integrated Governance Assurance Reports 2019/20 and Learning from Serious Incidents Reports 2019/20

The Committee received routinely considered safety, effectiveness and experience of patients through a Quarterly Integrated Governance Assurance Report and a Quarterly Serious Incidents and Learning Report. The report provides the Committee with the assurance it needs that the clinical governance arrangements are in place and that staff are being open by reporting incidents, clinical and non-clinical, to ensure patients and staff safety is maintained; and that lessons are learned from incidents.

Care Quality Commission (CQC)

The Committee received a progress report and action plan against the May 2018 CQC inspection findings at each of its meetings held over the year. The Committee received reports in January and February 2020 detailing the findings of the CQC unannounced inspection visit and Well Led Review, held 3 December 2019 and 14-16 January 2020 respectively, and the subsequent warning notice in relation to Medicines Management systems and processes. The Committee continued to receive an update on immediate and follow up actions taken in response to the warning notice and the inspection visit of December 2019. The Committee also commissioned quarterly assurance reports from Medicines Management to maintain oversight, of which the first report was reviewed by the Committee at its meeting held 24 February 2020.

Clinical Audit Work Programme
The Committee received the Clinical Audit Report 2018/19 at its meeting on 23 September 2019. The Committee had previously received and approved the Clinical Audit Forward Plan for 2019/20 at its meeting of 15 March 2019 which provided assurance in respect of the Trust's programme of clinical audit and the level of engagement. The Committee expected to receive the Forward Plan for 2020/21 in March 2020 however agreed to receive at its meeting in April 2020 to accommodate senate meeting schedules.

Maternity Picker Survey 2019
The Committee received the outcome of the Maternity Picker Survey 2019 at its meeting on 24 February 2020. The results from the survey, as in previous years, demonstrated that the Trust needed additional focus on Post-natal care in hospital as an area for improvement, however the Trust had improved the position from the 2018 survey. The Committee documented that the response rate remained low and the Trust had been identified as a pilot site by the CQC for a repeat Maternity survey to test the uptake of an online questionnaire rather than a paper-based format.

Local Safety Standards for Invasive Procedures (LocSSIP)
The Committee received regular assurances on the progress of work undertaken by the LocSSIP implementation group, noting that MIAA had undertaken an Internal Audit review of LocSSIPs during 2019/20 which had provided moderate assurance. Further assurance was provided to the Committee including correspondence from Liverpool CCG acknowledging the Trusts progress and commitment to improving patient safety.

CNST- Maternity Incentive Scheme
The Committee continued to review progress and action plans to deliver the required safety action standards for the Maternity Incentive Scheme year 3, with a focus on reviewing progress against safety action 3, ATAIN (Avoiding Term Admissions into Neonatal units). The Committee received the first monthly CNST Assurance report at its meeting on 23 March 2020.

PLACE Annual Report
The Committee received the Patient Led Assessments of the Care Environment annual assessment 2019 and action plan arising from the assessment. The Trust PLACE Assessment was carried out on 10 October 2019. Results had been published nationally in February 2020 with the Committee receiving the report at its meeting in March 2020. The Committee noted that the action plan would be developed and monitored by the Experience Senate, and was assured by plans to conduct an accessibility audit would further improve the position ahead of the 2020 PLACE inspection.

Equality and Human Rights
The Committee received quarterly progress reviews of Equality and Human Rights Goals 1&2 (Better health outcomes for all & Improved patient access and experience). For the Trust to be able to be graded as achieving for each outcome the Committee has over the year reviewed evidence against an agreed action plan and noted that in all aspects evidence provided supported the view that the Trust was making progress in achieving the goals.

Safeguarding
The Committee received the Safeguarding Annual Report 2018/19 at its meeting on 21 October 2019. The Committee and Trust have maintained their focus on safeguarding of children and vulnerable adults during the year, receiving regular chair reports from the Hospital Safeguarding Board.

Research and Innovation Annual Report and Strategy

The Committee received the annual report 2018/19 at its meeting held on 24 June detailing the Trust's research and development activities that supported the development of the Strategy. The Committee was assured that there had been a successful delivery of the Trust Research Strategy during 2018/19.

Clinical Case for Change
The Committee reviewed progress of clinical sustainability in relation to the clinical case for change and the mitigations and counterfactual case. It was noted that the primary responsibility of the Committee was to focus on the safety of services and clinical sustainability. The financial viability and business case modelling would be the responsibility of the Finance, Performance and Business Development Committee.

Health and Safety
The Committee reviewed the annual report 2018/19 and monitored progress against the health and safety self-assessment gap analysis.

Seven Day Working Board Assurance
The Committee reviewed the six-monthly self-assessment audit against the four priority standards at its meetings held in July and October 2019 and monitored Trust compliance.

National Initiatives
The Healthcare Safety Investigation Branch (HSIB)
The Committee reviewed the Trust involvement in the national initiative to review 1000 serious maternity incidents which commenced in February 2019.
The NHS Patient Safety Strategy
The Committee reviewed the national strategy which sits alongside the NHS Long Term Plan. It was agreed to develop a Patient Safety Strategy Local Delivery Plan.

Other Care related surveys and external assurance
The Committee received reports and associated action plans from the following during 2019/20: In Patient Gynaecology survey; Human Fertilisation and Embryology Authority (HFEA) Inspection Report; MIAA Quality Spot Check Audits for Gynaecology, Bedford and Maternity; Cancer National Inpatient Survey.

Other internal care quality related internal reviews
The Committee also reviewed a number of internal reports to provide assurances relating to quality of patient care during 2019/20, these included the following: Making Every Contact Count; Annual Complaints Report 2018/19; NICE Annual Report 2018/19; Pathology Assurance Report; Annual Security Management Report; and the Legal Services Annual Report.

Chairs Reports and Terms of reference of reporting Committees/Senates/Groups
The Committee received and approved the terms of reference of its reporting committees/ senates/groups in April 2019 and received assurances at each meeting from and provided challenges against the Chairs reports the Committee received from the committees/ senates/groups.

2020/21 Quality Committee Terms of Reference and Business Cycle
The Committee comprehensively reviewed the business cycle ahead of approval. These were both reviewed and approved by the Committee.

Conclusion
In evaluating its achievements it is concluded that the Quality Committee has achieved its objectives for the Financial Year 2019/20.

Work planned for 2020/21

A full work plan has been developed and approved by the Committee at its meeting on 23 March 2020, the work plan includes, but not restricted to the following items:

- To support development and monitor progress against the Quality Strategy for 2020/25;
- To review and recommend to the Board of Directors the 2019/20 Quality Report;
- To consider the impact of the Trust's financial position on quality of safe clinical services;
- Review and scrutinise the risks assigned to the Committee in the BAF and agree annual risk appetite statement;
- Review lessons learnt and trends from Serious Incident reports, clinical performance reports;
- Receive the Infection Control Annual Report
- Review assurances that the Trust has in place effective governance systems, risk management and quality improvement arrangements and identifying key concerns for the attention of the Board of Directors;
- Receive assurance from the Safety, Experience and Effectiveness Senates, Corporate Risk Committee and Hospital Safeguarding Board as to progression of work plans and escalation of risks and issues.
- To review and consider the Committees Terms of Reference.

Susan Milner CHAIR
Quality Committee
April 2020

Quality Committee **Attendance at Committee: April 2019 – March 2020** **Appendix 1**

Committee Member	Job Title	April 2019	May 2019	June 2019	July 2019	Sept 2019	Oct 2019	Nov 2019	Jan 2020	Feb 2020	March 2020	% attendance
Susan Milner	Non-Executive Director (Chair)	✓	✓	✓	**AP**	✓	✓	✓	✓	✓	✓	**90**
Phil Huggon	Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**100**
Ian Knight	Non-Executive Director	✓	✓	✓	✓	✓	✓	AP	✓	✓	✓	**90**
Louise Kenny	Non-Executive Director	✓	AP					AP		✓		**20**
Caron Lappin	Director of Nursing & Midwifery (as of July 2018)	✓	AP	✓	✓	✓	✓	✓	✓	✓	✓	**90**
Janet Brennan	Deputy Director of Nursing & Midwifery	✓	✓	✓	✓			✓	✓	✓	AP	**70**
Loraine Turner	Interim Director of Operations	AP	✓	AP		NM						**25**
Gary Price	Director of Operations (as of Sept 2019)					✓	✓	✓	✓	✓	✓	**100**
Andrew Loughney	Medical Director (as of Sept 2019)	NM					✓	✓	✓	✓	✓	**100**
Devender Roberts	Acting Medical Director (01 April 2019 – 31 Aug 2019)	✓	✓	✓	✓	✓	See below attendance list					**100**
Jenny Hannon	Director of Finance	✓	✓	✓	AP	✓	✓	✓	✓	✓	✓	**90**
Michelle Turner	Director of Workforce & Marketing	✓	✓	AP	✓	AP	✓	✓	✓	✓	✓	**80**
Christopher Lube	Head of Governance	✓	✓	✓	✓	✓	✓	✓	AP	✓	✓	**90**
Other Attendees												
Colin Reid	Trust Secretary (until end Sept 2020)	✓	✓	✓	✓	✓						
Paul Buckingham	Interim Trust Secretary (Oct until end Feb 2020)					✓	✓	✓	✓	✓		
Mark Grimshaw	Trust Secretary (as of March 2020)										✓	
Devender Roberts	Deputy Medical Director	See membership above					✓		✓	✓	✓	
Robert Clarke	Chairman		✓		✓	✓		✓	✓	✓	✓	
Kathryn Thomson	Chief Executive					✓			✓	✓	AP	
Melanie Pickering	Head of Nursing for Gynaecology	✓				✓						
Sarah Sherrington	Operational Manager Gynaecology	✓		✓	✓							
Tracy Ellery	Non-Executive Director	✓				✓						

Clare Fitzpatrick	Head of Maternity		✓									
Louise Hardman	Research & Development Manager			✓								
Mark Turner	Director of Research & Development			✓								
Richard Strover	Head of Information					✓						
Christopher Dewhurst	Clinical Director of the Neonatal Partnership					✓						
Amanda McDonough	Associate Director of Safeguarding						✓					
Jennifer Huyton	Strategic Finance Manager						✓					
Dawn Valentine-Gray	Lead Cancer Nurse							✓				
Daniel Collins	Deputy Chief Pharmacist								✓			
Bashar Chriebati	Project Office Administrator, IMT Virtual meeting support										✓	

A quorum shall be three members including two Non-Executive Directors and one Executive Director (one of whom must be either the Medical Director or Director of Nursing and Midwifery or their deputy). The Chair of the Trust may be included in the quorum if present.

Board of Directors

Committee Chair's report of Finance, Performance and Business Development (FPBD) Committee meeting held 21 April 2020

1. Was the quorate met? Yes (meeting was held virtually)

2. Agenda items covered

- **Covid-19 Response:** The Committee received an in-depth position update on the Covid-19 pandemic including the operational, financial and strategic impacts, governance implications, IM&T and the work being undertaken on recovery planning. The Committee noted the Trust decision to maintain internal monitoring despite a national pause on the requirement to provide external monitoring. It was noted that Covid-19 had caused a pressure on delivery of some of the CIP workstreams. The Committee was assured by steps undertaken to manage the current position and the recovery planning to support an efficient return to business as usual.
- **Finance Performance Review Month 12 2019/20:** The Committee received a report on the Month 12 finance position noting that, as at 31 March 2020, the Trust was reporting a full year surplus of £0.3m. The Committee commended both the capital expenditure achieved and the improved aged debtors balance by year end.
- **Operational Performance Month 12 2019/20:** The Committee received a report on Operational Performance as at Month 12 2019/20. The Committee noted that the position in relation to performance against RTT and Cancer Standards had improved but were likely to deteriorate in future months as a result of the Covid-19 pandemic. It was reported that all cancelled operations had been risk stratified and remain under review.
- **Neonatal Capital Programme Build Update:** The Committee noted the decision to proceed with the build, noting the additional measures in place due to COVID-19 and that there were currently no reported issues with the supply chain and business continuity plans in place from the contractors. The Project Board would continue to closely monitor the position. The Committee noted that the Trust would benefit from the Health Secretary's recent announcement to write off £13b of NHS debt as this would include the Neonatal capital support loan which would be converted into Public Dividend Capital (PDC).
- **FPBD Committee Effectiveness Annual Review:** The Committee approved the Committee annual review as a good reflection of work undertaken during the period 2020/21. The Committee considered the annual review of the NHSI Enforcement Undertaking as a historic matter which required resolving with NHSI/E. The Committee was informed that NHSI/E had confirmed that the matter would be addressed formally on behalf of the Trust however their meeting schedule was on hold to respond to Covid-19 matters.
- **Corporate Objectives 2020/21:** The Committee noted a revised set of 2020/21 corporate objectives since the last meeting and approved a review at 3 months.
- **Chairs report:** The Committee received and noted the Chair's report from the EPRR Committee held 6 April 2020.

3. Board Assurance Framework (BAF) risks reviewed

The Committee reviewed the risks that it was accountable for within the BAF. No changes to existing risks were identified as a result of business conducted during the meeting. The Committee noted the inclusion of the new overarching Covid-19 risk of which this Committee would be responsible. The new narrative for the Covid-19 risk was approved.

4. Escalation report to the Board on Performance Measures

The Committee highlighted continued potential impact on performance measures going forward in response to the COVID-19 pandemic.

5. Issues to highlight to Board

None

6. Action required by Board

The Committee recommend to the Board:

- Approval of the Committee Effectiveness Annual review (enclosed)
- Approval of the corporate objectives 2020/21 against the key strategic aims for which this Committee is responsible
- Approval of inclusion of a new BAF risk number 2340: Covid-19

Jo Moore
Chair of FPBD Committee
21 April 2020

Liverpool Women's NHS Foundation Trust

Finance, Performance & Business Development Committee Annual Report 2019/20

The Finance, Performance & Business Development Committee

The Committee is responsible for reviewing the Trust's financial strategy, performance and business development.

It completes these duties by undertaking the following:

Finance and performance

a. Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board.
b. Review progress against key financial and performance targets
c. Review on behalf of the Board, financial submissions (as reported in the Financial Performance Report) or others, as agreed by the Board, to NHS Improvement for consistency on financial data provided.
d. Review the service line reports for the Trust and advise on service improvements
e. Provide oversight of the cost improvement programme
f. Oversee external financing & distressed financing requirements
g. Oversee the development and implementation of the information management and technology strategy
h. Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework
i. To undertake an annual review of the NHS Improvement Enforcement Undertaking.
j. To review and receive assurance on the appropriateness of the Trust's Emergency Planning Resilience & Response processes and procedures.

Business planning and development

k. Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management
l. Advise the Board and maintain an oversight on all major investments, disposals and business developments.
m. Advise the Board on all proposals for major capital expenditure over £500,000
n. Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy

This remit is achieved through the Committee being appropriately constituted, and by the Committee being effective in ensuring internal accountability and the delivery of assurance services.

This report outlines how the Committee has complied with the duties delegated by the Trust Board through the terms of reference.

Constitution

The Finance, Performance and Business Development Committee is accountable to the Board of Directors.

Membership during the year comprised;

- Non-Executive Director (Chair)

- Two additional Non-Executive Directors
- Chief Executive
- Director of Finance
- Director of Operations
- Director of Nursing and Midwifery

Meetings were also attended by other executives and senior management staff as appropriate.

The Committee met in accordance with the frequency laid out in its terms of reference which is at least eight times per year. The Terms of Reference were reviewed in April 2019 for 2019/20 and further amended in September 2019.

Ten meetings were held during the financial year 2019/20 to reflect the challenges faced by the Trust. Members are able to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference.

The Committee was quorate for all meetings held. The Terms of Reference requires that all members of the committee attend a minimum of 50% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2019/20 together with the names of senior management who were invited to attend during the year. All members of the Committee attended 50% or more of the meetings during 2019/20.

Key Achievements

Significant financial, operational and strategic matters were adequately discussed with appropriate regard to risk, generating appropriate actions which were followed up on a timely basis. Key achievements and areas of review are noted below:

Financial Performance 2019/20

The Committee reviewed financial performance throughout the year in line with submissions to the regulator, noting areas of under and over performance. Specific issues in relation to the recurrent delivery of the CIP program were explored. The Committee noted that the financial plan would be delivered despite these challenges, largely as a result of the block contract arrangement in place and welcomed an early response to the impact of this on future years. The Committee noted that the Trust had repaid its Distressed Financing Loans in full during the year 2019/20.

The Committee received quarterly Treasury update reports for wider financial assurance. The Committee also noted the significant overdue debt from a private provider of maternity services and the subsequent administration of the same provider on 29 July 2019.

Monitoring the Trust CIP programme

The Committee received a full year post implementation review of the CIP programme 2018/19 at its meeting held on 24 June 2019. The Committee was assured that the financial and quality impacts of the 2018/19 cost improvement programme were taken into account when designing the 2019/20 CIP Programme. The Committee received a full mid-year review of the 2019/20 CIP programme at its meeting on 21 October 2019, noting schemes with elevated or potentially elevated risk and those having a positive impact.

Operational Performance 2019/20

The Committee reviewed operational performance and delivered oversight of the 18 week RTT and Cancer recovery plans and forward trajectories, noting remedial actions.

2019/20 Operational Plan 6 Monthly Review

The Committee noted progress against the key areas of Future Generations, Quality Strategy, Workforce, Membership, Service Plans and Finance and Performance.

Financial and operational planning 2020/21

The Committee undertook an early review of the overarching 2020/21 Planning Assumptions in preparation of receipt of the operational and financial plan for 2020/21. The Committee noted the operational planning process and contract negotiations with commissioners had been suspended as a result of the COVID-19 pandemic.

Preparing for 2020/21 Commissioning Negotiations

The Committee received a detailed review of services activity, demand and capacity planning to support business planning for 2020/21 in response to underlying activity in maternity and neonatal declining and a depressed activity in gynaecology due to lack of capacity. This was supported with high levels of clinical engagement and underpinned the 2020/21 budget setting process.

Strategic Options

The Committee received regular updates relating to strategic options and progress made by the Future Generations programme.

Long Term Plan and Oversight Framework Update

The Committee supported Trust plans in relation to implementing the NHS Long Term Plan and the single oversight framework.

IM&T strategy

The Committee monitored the progress of the implementation of an Electronic Patient Record (EPR). The Committee noted the issues, risks, and timescales implicated by an exit plan from the supplier and explored future plans to develop EPR in an alternative way.

The Committee continued to receive regular updates on progress with the Global Digital Exemplar Fast Follower Programme, detailing new digital clinical initiatives which would impact positively on the quality of care delivered. It noted that the Trust continued to achieve all requirements within agreed timescales during 2019/20 and successfully achieved the final milestone 4 during March 2020.

The Committee received Information Governance Updates which focussed on General Data Protection Regulations (GDPR), Data Security and Protection Toolkit (DSP) and ICO reportable incidents. It was noted that the Trust received no new ICO reportable incidents during 2019/20.

The Committee also reviewed a progress update of IM&T actions taken in relation to the CQC inspection findings relating to clinical systems and subsequent action plan.

The Committee received regular updates from the Digital Hospital Committee in the form of a Chairs report.

Neonatal Redevelopment Build

The Committee received a project progress update at every meeting held during 2019/20 and oversaw developments on behalf of the Board of Directors. The Committee was assured by operational progress achieved during 2019/20.

Neonatal Single Service

The Committee continued to monitor progress of the developments with Alder Hey NHS FT to establish contractual arrangements, governance and operational agreements to advance the neonatal single service business case as submitted to NHSE.

Genetics Service Transfer
The Committee received regular progress updates in relation to the transfer of services taking place on 1 August 2019.

BREXIT arrangements
The Committee received status updates in relation to the action plan in place with regards to the Operational Readiness of the Trust in the event of a 'no deal' Brexit.

Reference Cost Process Sign off
The Committee received the Reference Cost Process on behalf of the Board of Directors as per NHSI best practice guidance at its meeting held 24 June 2019 and subsequently approved the return at its meeting held on 23 September 2019.

Estates Return Information Collection (ERIC) sign off
The Committee received the annual ERIC return prior to submission to NHSI noting the level of rigour and challenge around the submission.

Business Assurance Framework (BAF)
The Committee regularly reviewed the Board Assurance Framework risks assigned in line with the business cycle of activities. The Committee held discussions over the rating of specific risks attributable to the Committee noting that they were being managed appropriately. The Committee reported all recommended changes to the BAF at the following Board of Directors meeting for approval.

Emergency Planning Resilience and Response (EPRR) Review
The Committee received the EPRR bi-annual review at its meeting on 25 February 2020 and annual assurance noting significant progress made against EPRR requirements. Based upon the assurance received the Committee agreed to receive the report on an annual basis going forward.

Corporate Objectives Outturn 2019/20 and Corporate Objectives 2020/21
The Committee reviewed the performance for the year against the Corporate Objectives 2019/20 aligned to its terms of reference; and the Corporate Objectives 2020/21.

Review of Risk Appetite Statement 2020/21
The Committee performed a review of the Risk Appetite Statements for 2020/21 that related to the Committees sphere of responsibility: to be ambitious and efficient and make the best use of available resources. The Committee reviewed the risk appetite for this objective and agreed that the level of risk appetite was appropriate and would not change from the risk appetite in 2019/20.

Marketing Strategy
The Committee received the Marketing Strategy Review and was assured of achievement of the 2019/20 Communications and Engagement Plan objectives.

2020/21 FPBD Terms of Reference and Business Cycle
The Committee comprehensively reviewed the terms of reference and business cycle ahead of approval.

Sub-Committee Review
The Committee received regular updates from

- Information Governance Committee
- Emergency Planning Resilience & Response Committee
- Digital Hospital Sub-Committee

Escalating risks as required.

Conclusion

In evaluating its achievements it is concluded that the Finance, Performance & Business Development has achieved its objectives for the Financial Year 2019/20.

Work planned for 2020/21

- Review developments and options in terms of the Future Generations Strategy
- Review and consider the impact of the Trust's financial position on the wider organisation and NHSI undertakings
- Review progress against key financial and performance targets, including CIP
- Review performance against the operational plan
- Monitor progress to recover the cancer target and referral to treatment target position
- Monitor progress and governance of the Neonatal Capital Build and Neonatal Single Service
- Continue to monitor all business developments and key service changes
- Continue to oversee the EPR project and monitor risks associated with delivery
- Approve the Long Term Plan and 2020/21 and 2021/22 operational plan, taking into account the wider Liverpool Place and C&M HCP plans
- Monitor the operational performance and financial impacts during and following the COVID-19 pandemic
- Regular review of BAF risks assigned to the Committee

Jo Moore - Chair
Finance, Performance & Business Development Committee
April 2020

Finance, Performance & Business Development Committee Attendance at Committee: 2019/20 Appendix 1

MEMBERS	JOB TITLE	April 2019	May 2019	June 2019	July 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	%
Jo Moore	CHAIR Non-Executive	✓	✓	✓	AP	✓	✓	✓	MTG NOT HELD	✓	✓	AP	80
Ian Knight	Non-Executive	✓	✓	✓	✓	✓	✓	AP		✓	✓	✓	90
Phil Huggon	Non-Executive	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	100
Tracy Ellery	Non-Executive	✓	✓	✓	✓	✓	AP	✓		✓	✓	✓	90
Jenny Hannon	Director of Finance	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	100
Kathryn Thomson	Chief Executive Officer	AP	✓	✓	✓	✓	✓	AP		✓	✓	AP	70
Gary Price	Director of Operations	Non member				✓	✓	✓		✓	✓	✓	100
Loraine Turner	Interim Director of Operations	AP	✓	AP	Non member								
Caron Lappin	Director of Nursing & Midwifery	✓		✓		AP	✓	✓		AP	✓	AP	50
Represent quorum if needed													
Robert Clarke	Chair		✓	✓	✓	✓	✓	AP		✓	✓	✓	
Invited Attendance													
Eva Horgan	Deputy Director of Finance	✓	AP	✓	✓	✓	✓	✓	MTG NOT HELD	✓	✓	✓	
Andrew Loughney	Medical Director							✓		✓			
Claire Scott	Head of Management Accounts		✓										
David Walliker	Chief Information Officer		✓			✓							
Colin Reid	Trust Secretary (until end Sept 2020)	✓	✓	✓	✓	✓							
Paul Buckingham	Interim Trust Secretary (Oct until end Feb 2020)					✓	✓	✓		✓	AP		
Mark Grimshaw	Trust Secretary (as of March 2020)											✓	
Sandra Goulden	Interim Chief Information Officer (as of June19)			✓	✓								
Sarah Sherrington	Interim Service Improvement & Business Manager			✓	✓								
David Dodgson	Financial Controller						✓						
Matt Connor	Chief Information Officer									✓	✓	✓	

The quorum shall be three members including at least two Non-Executive Directors (one of whom must be the Chair or Vice Chair of the Committee), and one Executive Director. The Chair of the Trust may be included in the quorum if present.

BOARD OF DIRECTORS

Chair's report of Putting People First Committee held on Monday 20 April 2020

1. **Was the quorate met?** Yes (meeting was held virtually)

2. **Agenda items covered:**

- **Risk Appetite Statement:** The Committee confirmed that they had considered and approved the risk appetite levels and statement outside of the meeting to meet end of year timescales.
- **Covid-19 Update:** The Committee received an in-depth position update with regards to supporting and managing the workforce in response to the coronavirus situation. It was confirmed that currently safe staffing levels are being maintained. It was noted that the workforce had responded positively to the challenges and demonstrated high levels of flexibility and cross-team working. Work would continue to focus on supporting staff to stay safe and well within work.
- **Board Assurance Framework Workforce Risks:** The Committee noted the inclusion of a new overarching Covid-19 BAF risk. The Committee approved the reduction of risk score for risk number 2293: Staff Engagement from 10 to 8.
- **Corporate Objectives year-end review 2019/20 and draft objectives 2020/21:** The Committee was assured by progress identified against the corporate objectives 2019/20. The Committee discussed and approved the draft corporate objectives for 2020/21.
- **Committee Terms of Reference:** The Committee reviewed and approved the committee terms of reference for 2020/21 subject to the inclusion of explicit responsibility to equality and diversity matters on behalf of the Board.
- **PPF Effectiveness Annual Review:** The Committee approved the committee annual review as an accurate reflection of work undertaken during the period 2020/21.
- **Putting People First Strategy 2019/24 Annual Review:** The Committee was assured by the in-depth appraisal of achievements against the putting people first strategy during year 1 provided. The Committee congratulated the team and supported the approach into year 2.
- **NHS Staff Survey 2019 Results and Action plan:** The Committee received the results from the 2019 national staff survey. The Committee noted a consolidated improvement in the staff engagement score which supported the recommendation to reduce the associated BAF risk. The Committee supported a focus for 2020/21 should be on the quality of appraisals.
- **Guardian of Safe Working Hours (Junior Doctors) Q4 2019/20** – The Committee was assured doctors in training were working to compliant rotas and shift patterns.
- **Policy Update –** The Committee approved the Conflict of Interest Policy.

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

The Committee recommended a reduction of risk score for Staff Engagement from 10 to 8 as a result of business conducted during the meeting. The new narrative for the Covid-19 risk was noted.

4. **Escalation report to the Board on PPF Performance Measures**

None

5. **Issues to highlight to Board**

None

6. Action required by Board

The Committee recommends to the Board:

- ~ Approval of the corporate objectives 2020/21 against the key strategic aims for which this Committee is responsible
- ~ Approval of the Committee terms of reference (enclosed)
- ~ Approval of the Committee Effectiveness Annual review (enclosed)

Tony Okotie
Chair of Putting People First Committee
Date 20 April 2020

Liverpool Women's NHS Foundation Trust

Putting People First Committee Annual Report 2019/20

Putting People First Committee

The aim of the Putting People First Committee is to develop and oversee the implementation of the Trust's People Strategy, providing assurance to the Board of Directors that this is achieving the outcomes sought and required by the organisation. The terms of reference of the Committee were reviewed in April 2019 and further amended in September 2019 and are as follows:

In discharging these duties the Committee is responsible for:

a. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process
b. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee)
c. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce
d. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors
e. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues
f. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys
g. Reviewing and approving partnership agreements with staff side
h. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues, including but not limited to equality and diversity
i. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings
j. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required.
k. Receiving and considering issues from other Committees when appropriate and taking any necessary action.

This remit is achieved firstly, through the Committee being appropriately constituted, and secondly, by the Committee being effective in ensuring internal accountability for implementation of the strategy through appropriate assurance mechanisms.

This report outlines how the Committee has complied with the duties delegated by the Trust Board through its terms of reference.

Constitution

The Committee membership (as appointed by the Board of Directors) comprises:

- Non-Executive Director (Chair)
- 2 other Non-Executive Directors

- Director of Workforce & Marketing
- Director of Nursing & Midwifery
- Director of Operations
- Staff Side Chair
- Medical Staff Committee representative
- Senior Finance Manager

In addition the Committee was supported by senior HR and OD staff, Chair of Education Governance Committee, a representative from the Nursing & Midwifery Board, and with other officers attending as required.

Members can participate in meetings in person or by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum.

This is a sub-committee of the Board of Directors established to ensure effective implementation of the integrated workforce and organisational development strategy.

Five meetings were held during the financial year 2019/20. An attendance sheet is attached for information at the end of this report (appendix 1). There were issues in the early part of the year due to the unavailability of the Director of Operations due to vacancy and subsequently sickness.

The Chair provides a chairs report into the Board of Directors after every meeting.

Achievements against objectives

The Committee's primary focus throughout the year was to move forward plans to achieve the five year Putting People First Strategy. The Committee also focused on the key Board Assurance Framework risks remitted to the Committee for oversight, review and update. These included:

- The risks associated with not having a well-led, engaged, motivated and effective workforce
- The risks associated with not having a fully resourced, competent & capable clinical workforce

In 2019/20, the Committee also;

- Agreed its Risk Appetite Statement for PPF relevant risks
- Undertook a deep dive and gained assurance with respect to workforce risks in Maternity, Neonates, Clinical Support Services, and Gynaecology Services. Staff Stories were also received for each of these areas
- Supported the development of the Fair & Just Culture project
- Received assurance that the key themes of the PPF strategy is in alignment with the NHS Interim People Plan, which supports delivery of the NHS Long Term plan.
- Monitored all workforce related Key Performance Indicators
- Reviewed the PPF related Corporate Objectives
- Gained assurance around the processes to deliver and monitor compliance with mandatory training requirements
- Considered the Annual Staff Survey results and subsequent action plans
- Gained assurance to the safe working practices of the junior doctor workforce from the Guardian of Safe Working and the GMC national survey for doctors in training.
- Received the medical revalidation and appraisal report and its assurance around these processes

- Received assurance of compliance with regulatory HEE education guidelines and standards. Reviewed the HENW Education Standards Audit and received assurance of compliance with this
- Received information relating to the key workforce risks and mitigations including succession plans for key specialist roles
- Gained assurance that there were no trends of concern with respect to the Trust's Disciplinary, Whistleblowing, Dignity at Work, Grievance and CEA processes
- Considered an operational review of sickness absence management and gained assurance that appropriate progress was being made in line with the Health & Wellbeing, Retention and Sickness Improvement programmes of work.
- Regularly reviewed the progress made against the Equality Delivery System Goals & WRES and identified the areas for improvement within the Trust and remitted the actions to the Diversity & Inclusion Committee.
- Gained assurance of successful contract management of the outsourced Payroll, Occupational Health and Recruitment services
- Ratified policies to ensure the HR policy schedule was in date and that all legal changes and changes to national policy were adhered to
- Received regular Director of Workforce and Marketing reports
- Reviewed the Volunteer Strategy and progress against its aims
- Reviewed the Communications, Marketing & Engagement Strategy and progress against its aims
- Supported development of the five year Nursing, Midwifery & AHP Strategy and reviewed safe staffing reports and Nursing and Midwifery revalidation for assurance.
- Received regular updates on the Leadership development programme and other key organisational development workstreams

The Committee reviewed and approved the following policies;

- Equality Impact Assessment Policy
- Performance Pay Progression Policy
- Special Leave Policy
- Maternity, Paternity & Adoption Leave Policy
- Volunteer Procedure
- Supporting Staff Following a Work Related Traumatic Event or Serious Incident Policy
- Induction Policy
- Mandatory Training Policy
- Temporary Staffing Policy
- Organisational Change, Pay Protection and Redundancy Policy
- Redeployment Policy
- Retirement Policy
- Special Leave Policy
- Job Planning for Consultant Nurses & Midwives
- Annual Leave Policy
- Secondments & Acting Up Policy
- Dignity at Work Policy
- Policy for Supervision and Assessing Competence of Medical Staff in Training
- Removal & Related Expenses for Consultant Medical Staff SOP
- Recruitment Policy
- Job Matching & Evaluation Policy
- Snr Medical Staff Covering Jnr Medical Staff (Out of Hours) Policy

The Committee received chair reports from the following reporting Committees:

- Partnership Forum
- Education Governance Committee

- Diversity & Inclusion Committee
- Health and Wellbeing Group
- NHSE Retention Group (until November 2019)
- NHSI Sickness Improvement Project (until September 2019)
- Joint Local Negotiating Committee

Conclusion

In evaluating its achievements it is concluded that the Putting People First Committee has achieved its objectives for the Financial Year 2019/20.

Work planned for 2020/21

In 2020/21 the Committee will continue to support the five year People Strategy and will seek progress reports on a regular basis.

The Committee will continue to strengthen its assurance approach by undertaking service 'deep dives' requiring leaders of the Trust's clinical and corporate services to present their key workforce risks and provide assurance to the Committee that these risks are appropriately identified, mitigated for and actively managed.

The Committee will continue to analyse trend data arising from the monthly KPI data and workforce planning reviews and again identify and mitigate any risks.

The Committee will meet five times per year and additional meetings will be arranged if necessary.

The main functions of the Committee remain the same as the previous year in:

- Ensuring appropriate levels of assurance are provided to the Board of Directors in relation to key risks relating to the workforce as identified in the Board Assurance Framework

- Overseeing progress of the People Strategy 2019/24

Tony Okotie Chair
Putting People First Committee
April 2020

Putting People First Committee Attendance Register 2019/20

A quorum shall be four members including: The Chair or at least one other Non-Executive Director; at least one from either Director of Workforce and Marketing or Director of Nursing and Midwifery; Director of Operations or their Deputy; Either Staff Side Chair or Medical Staff Committee representative

Committee Member	Job Title	23 April	24 June	23 Sep	25 Nov	20 Jan	% attendance
Tony Okotie	(CHAIR) Non-executive director	✓	✓	✓	**AP**	✓	**80**
Jo Moore	Non-executive director	✓	✓	✓	✓	✓	**100**
Dr Susan Milner	Non-executive director	✓	✓	✓	✓	✓	**100**
Michelle Turner	Director of Workforce and Marketing	✓	✓	**AP**	✓	✓	**80**
Caron Lappin	Director of Nursing & Midwifery	✓	✓	✓	✓	✓	**100**
Gary Price	Director of Operations	**NM**	**NM**	✓	**AP**	✓	**40**
Claire Scott	Senior Finance Manager			✓	**AP**	**AP**	**40**
Ms Kathryn Wooder	*Divisional Accountant (on behalf of Finance Manager)*		✓				
Victoria McKay	Medical Staff Committee Chair					**AP**	**0**
Linda Watkins	Director of Medical Education / Education Governance Committee *(on behalf of MSC Chair)*	✓		✓	✓	✓	
Liz Collins	Staff Side Chair	✓		**AP**	✓	✓	**80**
Amanda Cringle	** Staff Side Secretary (on behalf of staff side chair)*		✓		**X**		
In attendance							
Susan Westbury	Deputy Director of Workforce (until end May 2019)	✓					
Jeanette Chalk	Head of Operational HR / Interim Deputy Director of Workforce (as of June 2019-Dec 2019)	✓	✓	✓	✓		
Rachel London	Deputy Director of Workforce (as of Jan 2020)					✓	
Tracy Ellery	Non-executive director	✓					
Robert Clarke	Chairman	✓		✓	✓		
Janet Brennan	Deputy Director of Nursing & Midwifery	✓	✓	✓		✓	

Geoff Shaw	Guardian of Safe Working Hours	**AP**		**AP**	**AP**	**AP**	
Rochelle Collins	Medical Staffing Advisor			✓	✓	✓	
Jean Annan	Head of Learning	✓		**AP**	✓		
Kathryn Allsopp	HR Business Partner	✓	✓	✓	✓	✓	
Rachel Reeves	HR Business partner	✓		**AP**	✓	✓	
Angela Hughes	HR Business Partner					✓	
Chris McGhee	Freedom to Speak Up Guardian / Fair & Just Culture Project	✓	✓	✓			
Kevin Street	Freedom to Speak Up Guardian					✓	
Andrew Duggan	Head of Communications & Marketing	✓					
Clare Fitzpatrick	Head of Midwifery	✓					
Ms Anne Bridson	Learning & Development Facilitator		✓				
Ms Leanne Gould	HR Administrator		✓				
Nikki Maggs	Head of Nursing for Allied Health Professions			✓			
Devender Roberts	Deputy Medical Director and Consultant Obstetrician			✓			
Sarah Orok	Gynaecology Outpatient Manager					✓	
Mel Pickering	Head of Nursing					✓	
Rachel Mavers	Community Team Leader					✓	
Debbie Pink	Access Centre Manager					✓	
Kathryn Thomson	Chief Executive					✓	
Alison Murray	Matron, Intrapartum					✓	
Kirsty Cassidy	Neonatal Nurse				✓		
Jennifer Denney	Head of Neonatal Nursing				✓		
Valerie Irving	Matron, Neonatal				✓		

PUTTING PEOPLE FIRST COMMITTEE
TERMS OF REFERENCE

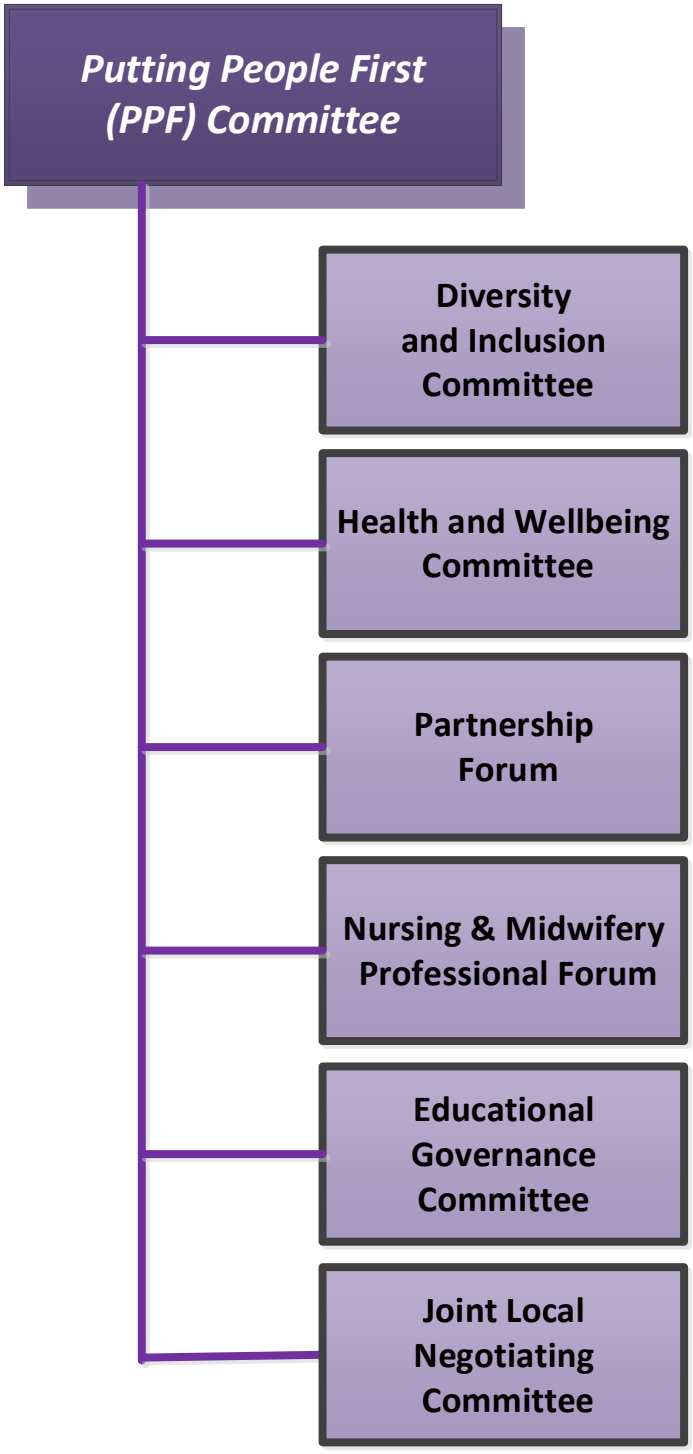
Constitution:	The Committee is established by the Board of Directors and will be known as the Putting People First Committee (the Committee).
Duties:	The Committee is responsible for: a. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process b. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee) c. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce d. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors e. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues f. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys g. Reviewing and approving partnership agreements with staff side h. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issuesMonitor and evaluate compliance with the public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics i. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings j. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where

	additional assurance is required, escalating to the Board of Directors as required. k. Receiving and considering issues from other Committees when appropriate and taking any necessary action.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • 2 other Non-Executive Director • *Director of Workforce & Marketing • *Director of Nursing & Midwifery • *Director of Operations • Staff Side Chair • Medical Staff Committee representative • Senior Finance Manager *or their nominated representative who will be sufficiently senior and have the authority to make decisions. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be four members including: • The Chair or at least one other Non-Executive Director • At least one from either Director of Workforce and Marketing or Director of Nursing and Midwifery • Director of Operations or their Deputy • Either Staff Side Chair or Medical Staff Committee representative
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members**

	Members will be required to attend a minimum of 75% of all meetings. **b. Officers** HR & OD Senior Team, Education Governance Chair, and a representative from the Nursing & Midwifery Board shall normally attend meetings. Members may send a nominated representative to attend meetings on their behalf when they are not available, provided they are sufficiently senior and have the authority to make decisions. Other executive directors, officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held at least 4 times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Putting People First Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the subsequent Board of Directors for assurance. Approved minutes will be made available to all Board members upon request. Approved chairs reports will also be circulated to members of the Audit Committee.

	The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Putting People First Committee.
Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; b) an Annual Report setting out the progress they have made and future developments; c) Terms of reference The following sub committees/groups will report directly to the Committee: • Diversity & Inclusion Committee • Health & Wellbeing Committee • Partnership Forum • Nursing & Midwifery Professional Forum • Educational Governance Committee • Joint Local Negotiating Committee
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Putting People First Committee:	20 April 2020
Approved by Board of Directors:	[7 May 2020]
Review date:	March 2021
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Appendix 1


Putting People First (PPF) Committee
Diversity and Inclusion Committee
Health and Wellbeing Committee
Partnership Forum
Nursing & Midwifery Professional Forum
Educational Governance Committee
Joint Local Negotiating Committee

	Agenda Item
MEETING	**Board**
PAPER/REPORT TITLE:	**COVID-19 Update**
DATE OF MEETING:	Thursday, 07 May 2020
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 recommended to note the update for information and assurance.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	N/A		
	Date of meeting			

Executive Summary

This paper summarises the Trusts response to date to the international Covid 19 (Coronavirus) pandemic. It details the Trusts response as a Category 1 responder under the Civil Contingencies Act in order to support our patients, our staff and the wider Health and Social Care System.

Report

1. Introduction

Covid 19 (Coronavirus) originated in China in December 2019 and rapidly spread through Asia and Europe. The NHS declared the coronavirus outbreak a national major incident on 3rd March 2020 requiring NHS Trusts to respond under the Civil Contingencies Act (1994). On March 11th 2020 the World Health Organization (WHO) declared this a global pandemic.

The major incident response requires business continuity measures to be enacted, potentially for several months with an unpredictable end date. This paper details the work undertaken to date by the Trust.

2. Key issues

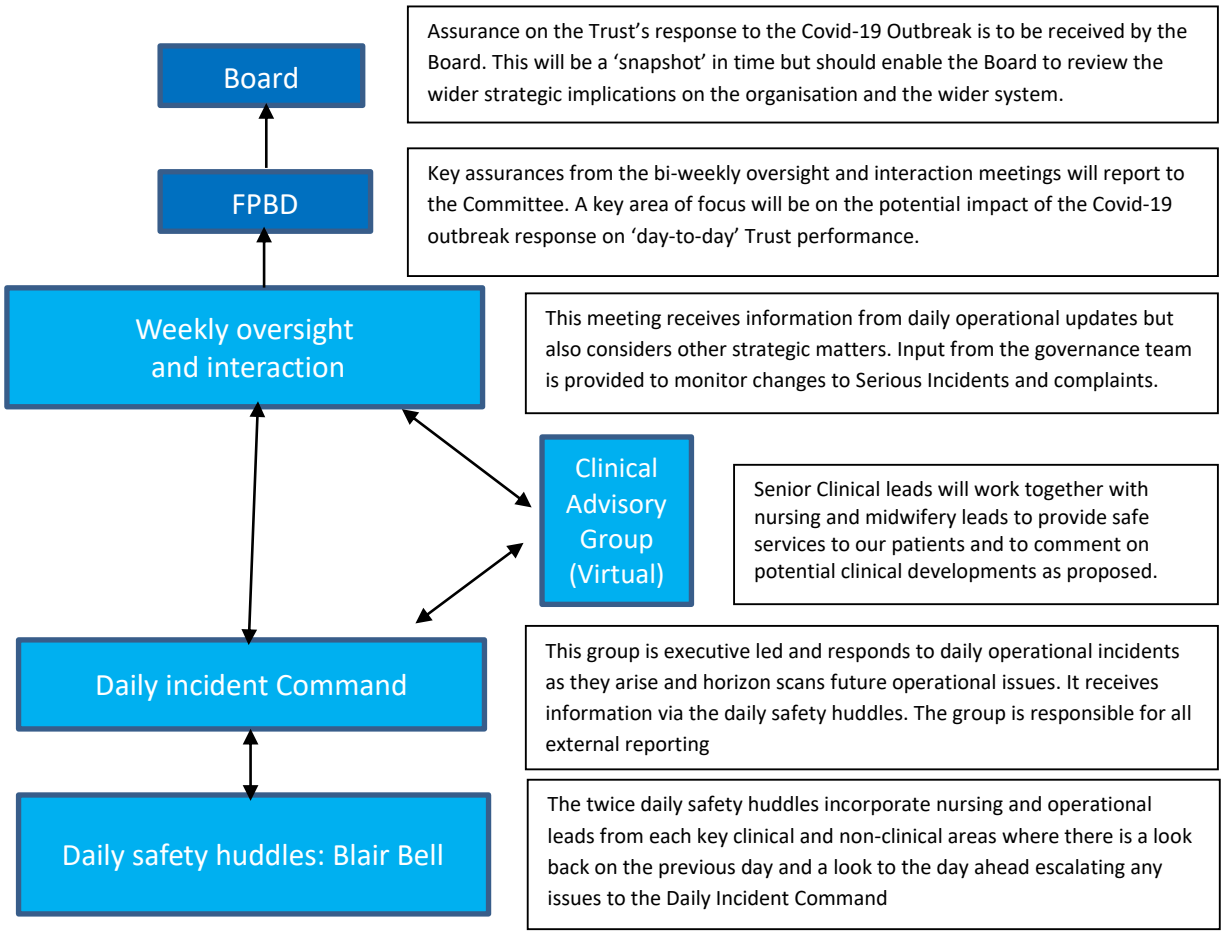
A flu pandemic is a "rising tide" event. These events typically continue for several months with slow and unpredictable sustained progression, a peak and a slow, unpredictable and sustained regression. Rising tide events are therefore one of the most challenging type of business continuity events to manage over a sustained period.

The Trust in response has enacted business continuity measures to this major incident. The Trust is under Command and Control of NHS I&E during this period.

During April 2020 the Trust saw an average 18% staff absence of which 13% was Covid-19 related.

Governance Structure and Processes

The response to the Covid-19 outbreak is generating a significant amount of information and guidance from various sources. Requests are also being made of the Trust to provide information to local, regional and national systems. The Trust has implemented a governance structure which is intended to ensure that there is a co-ordinated response to information being received and that is sufficiently agile for timely yet robust decision-making. The structure supports the Trust in managing the day-to-day demands whilst also remaining sighted on wider, strategic considerations.



Summary of key actions taken to date

Essential services have been prioritised; these are:

- Neonates
- Maternity and Obstetrics
- Gynaecology Emergencies
- Gynaecology Cancer
- Termination of Pregnancy

- Theatres and Anaesthetics
- Pharmacy
- Essential corporate services including estates, security and facilities
- Risk and Governance

Other services have been reduced or stepped down

- Fertility
- Routine Gynaecology outpatients and elective surgery
- Routine therapies
- Genetics
- Research and Development
- Non-essential corporate services

Personal Protective Equipment (PPE)

The oversight of PPE is provided by the daily Incident Command Team supported by procurement and clinical governance. To date the Trust has been able to supply all staff with PPE required.

Visitor restrictions

Visitor restrictions are in place in line with national guidance. These are regularly reviewed by the oversight and interaction group. Visitor restrictions are in place to reduce the interactions within the organization and therefore potential spread of Covid 19.

Virtual ways of working

The Trust has seen the rapid introduction of software that has allowed team meetings to be conducted virtually right through the organization. This has been done to stop the number of physical interactions and therefore contribute to the poetical reduction in spread of Covid-19. Virtual clinics have been established for some of our more vulnerable patients who may be able to have their consultation undertaken in this way.

Staff Wellbeing

There has been an increased focus on staff wellbeing with staff being reminded of the existing routes of support available to them via the Trust's occupational health and wellbeing services. National support lines have also been introduced as well as a raft of local measures to support our staff including free car parking and meals during this challenging period.

Clinical Governance

Clinical Governance is an essential service and will remain so through this pandemic. Staff are encouraged to report incidents relating to the pandemic to support the Trusts oversight of issues relating to patient care during this period

24/7 Management

The Trust has senior management and Executive presence daily within the organization during the pandemic period which supplements the already exiting senior management and executive on call rota

Mutual aid

The Trust has been able to offer mutual aid across Cheshire and Mersey to support the wider health and social care system:

- Medical step-down facility for Liverpool University Hospital
- Delivery of Cancer services for Cheshire and Mersey Trusts
- Agreement with LMS to support local Maternity services that may have staffing challenges
- Agreement with Alder Hey to increase support for babies on surgical pathway if required
- Sharing of PPE across the system during times of challenge

Recovery

NHSI&E have requested Trusts develop recovery plans for work stepped down. These plans need to consider a system response to recovery.

Work has started to collate some of the key lessons from our response to the Covid-19 pandemic. This has involved a project lead being identified who has been meeting with Executives and Senior Managers to consider the following issues:

- The specific Covid-19 responsibilities within portfolios
- What have we stopped doing as a result of Covid-19?
- What are we doing differently?
- What is the learning from the experience and therefore what will we carry on doing after the pandemic has passed?

Once the initial discussions have been held, the findings will be collated to inform next steps in the process.

Communications Approach

Messages at both national and local level are fast moving and changing daily. The Trust has adopted the approach of one centralised daily brief for staff. The daily brief also includes Frequently Asked Questions. A range of media is being adopted to ensure patients, visitors and their families are aware of the changing situation on the site including our social media channels. Issues such as short notice changes to visiting arrangements are being supplemented by text messaging and direct telephone calls in advance of appointments.

Risks

The Trust's Risk Management Strategy has been utilised to identify and determine the risks posed by the Covid-19 pandemic. An 'umbrella' Covid-19 BAF risk has been drafted and following consideration by the Board's sub-committees in April 2020, this is proposed for Board approval later in the agenda. It was agreed to develop a single BAF risk to provide a clear line-of-sight of the key risks, assurances and controls. The key risks the Trust has identified relate to; ensuring that 'business as usual' standards are retained, ensuring that robust recovery plans are in place and maintaining controls with regards to cyber-security and identifying fraud. Whilst an 'umbrella' BAF risk has been suggested, there is acknowledgment that Covid-19 will impact all Trust operations and therefore the interdependencies of risks across the whole BAF are being tracked.

3. Recommendation

The Board is recommended to note the update for information and assurance.

Agenda Item	

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**
DATE OF MEETING:	7th May 2020
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Choose an item. Gaynor Hales, Interim 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.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS*** ☒
LINK TO TRUST STRATEGY, PLAN AND	**1.** Trust Constitution ☐ **4.** NHS Constitution ☐ **2.** Operational Plan ☐ **5.** Equality and Diversity ☐

EXTERNAL REQUIREMENT	**3.** NHS Compliance ☒	***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 • Staffing relating to Covid-19	
PREVIOUSLY CONSIDERED BY:	Committee name	***Choose an item.*** Or type here if not on list: Click here to enter text.
	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.

Maternity has seen a decrease in fill rate in March due to sickness and maternity leave. 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.

Workforce reviews have been undertaken by the divisions which include succession planning. However, due to the COVID-19 pandemic these have not yet been signed off.

Nurse and Midwifery fill rates are reported externally however, during the pandemic this has been suspended. LWH are still collecting the data monthly.

The challenges and uncertainties of Covid-19 pandemic present some challenges for the workforce. Whilst the trust is not dealing with large numbers of Covid-19 positive patients, there remains a number of challenges for the LWH workforce. Due to Covid-19 there are a number of Health Care professionals unable to work, this is being monitored and managed daily. With the introduction of swabbing of index cases this has enabled the return of some health care professionals earlier than would have been prior to swabbing.

An increased consultant presence in the trust has provided trainees, nursing, midwifery and theatre colleague with support and confidence. The changes described are temporary, but evidence of benefit is being sought to inform longer term service planning.

At 27th April 2020 the overall absence rate for LWH was 14.43% This breaks down into 10.11% Covid-related absence and 4.32% non- covid related absence.

Nursing and Midwifery current absence is: 10.74% Covid-19 related 4.56% non-Covid-19 related
Medical staffing current absence is: 11.22% covid- related 3.06% non- covid related

LWH also have the opportunity to accept retirees/ returners via the NW region. To date LWH have accepted 1 retired Nurse and have requested from the region a number of nurses to support the neo-natal unit.

LWH have also accepted 24 3rd year students (N & M) in their last 6 months of training who are part of the workforce.

It is recognised at this time there is stress and anxiety amongst the staff and there have been many staff support measures implemented across the Trust.

Ward Staffing Levels – Nursing and Midwifery
Report March 2020

1.0 Introduction
This report provides a monthly summary of Safe Staffing on all inpatient wards across the Trust. It includes the safe staffing exception report related to staffing levels, incidents and red flags which are triangulated with a range of quality indicators for both nursing and midwifery.

2.0 Safer staffing exception report
The safer staffing fill rate (appendix 1) provides the established versus actual fill rates on wards split by registered and unregistered staffing hours and by day and night shifts. Fill rates are accompanied by supporting narrative by exception at ward level, and a number of related factors are displayed alongside fill rates to provide an overall picture of safe staffing.

- Sickness rate and vacancy rate are the two main factors affecting fill rates, a growing trend is maternity leave, especially within maternity division, and this is being closely monitored. It has been agreed that maternity can over establish by 10 midwives to cover maternity leave.
- The trust has introduced a ward accreditation system which is required to support the collection of quality indicators alongside real time patient safety flags. Ward accreditation baseline assessment was rolled out to 5 areas in April 2019. A further review of the 5 areas had been due to undertaken completing in March 2020. Due to the onset of the pandemic not all areas were accredited this will now have been completed by the end of May 2020. 5 other areas are starting audits as part of the accreditation programme and will be fully accredited by the end of 2020.
- 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 daily at entrances to wards, staffing data is also submitted monthly through a unify submission to the NHS choices site.

2.1 Summary of fill rates

The inpatient wards have been able to maintain safe fill rates during the month of March **2020.**

- Maternity has seen a decrease in fill rate
- Gynaecology has seen an increase in fill rate of care staff
- Neonates has had a drop in HCSW fill rate but is offset by registered staff

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 has been closed in March.

There is currently a review of Bands 2, 3 and 4 JD and competencies across the organisation to ensure consistency. This will be completed in July 2020.

2.2 Red Flags

In March there were 11 red flags reported (3 staffing shortfall)
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.

During Covid-19 HEE have agreed that students in the last 6 months of their training can support Trusts to assist with their burden and enable them to complete their training. During this time the students will be paid a band 4 which will be re-imbursed to trusts. LWH have agreed to take 24 students (17 midwifery & 7 Nursing) students in their last 6 months of training.

4.0 Vacancies

There are currently 5.95 wte Registered vacancies in Gynaecology. 0 vacancies in Maternity. 0 Vacancies in Neo-natal and in theatres.

Currently the Matron for CSS post is vacant. A review of the Job description has taken place, and this is currently out to advert.

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.

Annual workforce reviews have also now taken place across the divisions.

5.0 COVID-19

Since the onset of Covid-19 as of 27.04.2020 there are 10.74% Nurses & Midwives with Covid- 19 related absences across all divisions and 11.22% Medical staff. This is changing daily as staff return from isolation and others commence isolation. Each division is managing this daily with cross divisional support being offered when able. Some services have reduced considerably which is enabling this support to happen (Hewitt, Genetics and Gynaecology). LWH is also supporting LUFT with the transfer of patients onto the gynaecology ward. Although a total of 9 beds have been offered only 4 have been filled as LUFT have not had bed pressures. Training and support for staff is being undertaken to enable them to support other areas. Hewitt staff are also supporting the swabbing of staff service which is available 7 days per week.

A number of measures have been put in place to support the workforce:

- Staff helpline
- Daily walk rounds from MH first aiders
- Staff support walk rounds
- Free car parking
- Free meals
- Chaplaincy drop in
- Delivery of goods to areas
- Chill out area

Feedback from staff has overall been positive.

6.0 Medical Staffing

Urgent and semi-urgent work across obstetrics, gynaecology, neonatology and anaesthetics is presently taking longer to deliver than usual case-by-case because of the precautions that have had to be introduced during the Covid-19 pandemic. This additional medical input has, however, been mitigated in part by a reduction in benign gynaecological surgical workload as nationally mandated, in part by the transfer of SPA time into DCC time in consultants' working weeks and in part by the switch from academic to clinical activities for our academic staff. This has given us the opportunity to:

- introduce additional resilience into trainees' rotas
- provide a two-tier consultant gynaecologist rota separating out cancer and massive haemorrhage cover from more routine acute benign gynaecological work
- provide a two-tier consultant obstetrician rota, allowing for one consultant to be on site 24/7 and for a second to provide extra cover from home each night
- provide 24/7 on site consultant anaesthetist cover

There has been some strain on neonatal medical cover because of Covid-19 related trainee and consultant absences but the neonatal team have been given the ability to flex their working patterns as needed to maintain safe and effective medial staffing levels throughout. This has been achieved successfully so far.

In general, we believe that the increased consultant presence in the trust has provided trainees, nursing, midwifery and theatre colleague with support and confidence. The changes described are temporary, but evidence of benefit is being sought to inform longer term service planning.

7.0 Summary

During the months of **March 2020** 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.

Key issues to note:

- Maternity has seen a rise in bank costs and overspends with a reduction in births.
- There are a number of Nurses and Midwives off currently due to Covid-19, this is being monitored daily.
- There are a number of Medical staff currently due to Covid-19
- A number of supportive measures have been implemented to support staff.

8.0 Recommendations

The Board is asked to receive the paper for information and discussion.

Appendix 1

March 2020

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	90	97	100	97.1
Delivery suite	85.6	91.9	83.9	75.3
Mat Base	88	80	89.9	82
MLU	85.2	119.4	92.9	119.4
Neo-nates	124	91.9	125.4	90.3

	Agenda Item	
MEETING	**Trust Board**	
PAPER/REPORT TITLE:	**Care Quality Commission Update**	
DATE OF MEETING:	Thursday, 07 May 2020	
ACTION REQUIRED	**Assurance**	
EXECUTIVE DIRECTOR:	Gaynor Hales, Interim Director of Nursing and Midwifery	
AUTHOR(S):	Janet Brennan, Deputy Director of Nursing & 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:-….)***	***The Board is asked to note the warning notice, ratings, actions and findings arising from the CQC inspection approve the process for monitoring and tracking progress against actions.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable ***Click here to enter text.***		
	Date of meeting	***Click here to enter a date.***		

Executive Summary

The Care Quality Commission (CQC) carried out an unannounced inspection of the Trust from 3 - 5 December 2019 and an announced 'well-led' inspection from 14-16 January 2020.

The final inspection report was published on 23 April 2020 – the key highlights are as follows:

- The Trust received an overall rating of 'Good' with a 'Requires improvement' for Well- Led.
- Maternity received an overall 'Good' with 'Outstanding' for Responsiveness
- Gynaecology received an overall 'Requires improvement' with 'Good' for Caring
- Neonatal services received an overall 'Good'.

During the Core Services inspection conducted 3-5 December 2019, the CQC issued the Trust with a warning notice which stated a failure to ensure that systems and processes were effectively established to ensure the proper and safe management of medicines. The Trust responded to the warning notice by the deadline noting the immediate steps that had been taken to ensure patient safety was not compromised. Actions implemented following the warning notice are continuing.

There were overall 16 breaches of legal requirement and 23 points that the Trust should improve on to comply with minor breaches that did not justify regulatory action.

The Trust has developed an action plan to address these points and there is a requirement to respond to the CQC with an action plan by 29 May 2020. It is envisaged all the actions will be completed by December 2020. There are two actions from the 2018 CQC report which remain incomplete and will carry forward onto the 2020 action plan. These are relating to EPR.

Report

Background

The Care Quality Commission (CQC) carried out an unannounced inspection of the Trust from 3 - 5 December 2019 and an announced 'well-led' inspection from 14-16 January 2020. During the Core Services inspection conducted 3-5 December 2019, the CQC issued the Trust with a warning notice which stated a failure to ensure that systems and processes were effectively established to ensure the proper and safe management of medicines.

Key Findings

The inspection report was published on 23 April 2020 and the overall rating for the Trust remained at "Good" since the last inspection 2018.

The full report can be found on the following link:
https://www.cqc.org.uk/sites/default/files/new_reports/AAAK0639.pdf

The overarching Trust ratings from the inspection are shown below:

At core service level, three services were inspected.

- Maternity services remained 'Good' overall and remained 'outstanding' for responsiveness
- Neo-natal services were 'Good' overall, downgraded to 'Good' in Safe
- Gynaecology remained as 'Requires improvement' with 'Good' for Caring, but downgraded in Safe and Effective

Because of these changes, the aggregated ratings were downgraded for 'Well-led' to 'Requires improvement'.

Warning Notice

During the Core Services inspection conducted 3-5 December 2019, the CQC issued the Trust with a warning notice which stated a failure to ensure that systems and processes were effectively established to ensure the proper and safe management of medicines.

The Trust responded to the warning notice by the 10 January 2020 deadline, noting the immediate steps that had been taken to ensure patient safety was not compromised. An immediate action taken was to implement twice weekly audits of medicine management with any resulting issues escalated as appropriate. Further actions include:

- Cross Divisional audits.
- Quarterly safe and storage of medicine audits undertaken by pharmacy reporting to Medicines management committee and assurance through the Quality committee.
- Roll out of e-learning medicines management module.
- The development of a monthly ward audit programme (as part of ward accreditation) which will replace the twice weekly audits from June 2020.

- Development of a medicines safety group (May 2020) reporting into Medicines management Committee with assurance to the Quality committee.
- A weekly report of all medicine incidents is now sent to the Director of Nursing & Midwifery, Deputy Director of Nursing & Midwifery, the Medical Director and Deputy Chief Pharmacist.
- Individuals who continue not to follow medicines policies are in receipt of appropriate management using a fair and just approach.
- Internal review of theatres by an independent theatre specialist – action plan developed and monitored through CSS Divisional Board and assurance through safety senate.

The audits have demonstrated compliance with the failings identified by the CQC warning notice.

In addition, the Trust's Internal Auditor (MIAA) has partially (not completed fully due to Covid-19) undertaken an audit of compliance to provide external assurance. The findings so far indicate that the Trust has provided a comprehensive and robust response to the specific points highlighted by the CQC warning notice. This has included the development of a comprehensive action plan, staff communications, policy updates, enhanced audit activity and Sub-Committee Terms of Reference updates. Review of Divisional governance of the actions and testing of the actions put in place is currently being assessed. The internal audit report is due to be considered by the Audit Committee in May 2020 to test the strength of the assurances provided.

Regulatory actions

There were 16 identified 'must do' actions relating to breaches of regulation and 23 actions CQC recommend we 'should do' to prevent the Trust from failing to comply with legal requirements in the future. These are in addition to the warning notice noted above.

The 16 areas identified as breaches of regulation by CQC and these are split by the following areas:

- Trust wide
- Neonatal
- Maternity
- Gynecology

In addition, there were 23 actions that CQC recommend we should take to prevent us failing to comply with legal requirements in future or to improve services and these are split into the following areas:

- Gynecology
- Neonates

Action Planning

The Trust has begun work on addressing all the areas for improvement identified in the report with several actions being addressed at the time of the inspection and in response to the warning notice. An overarching action plan has been developed which will be submitted to the CQC prior to 29 May 2020. This is attached as appendix 1. The action plan has been formatted to enable the Board to retain oversight of the Trust's response to the CQC report.

The action plan and evidence will be added to the CQC module in the Ulysses system to allow for tracking and monitoring.

The overarching action plan will be monitored for assurance at the Quality Committee on a monthly basis, with an exception report to Board. Divisions will monitor their actions at Divisional Boards and meet with the Director of Nursing & Midwifery and the Deputy Director of Nursing & Midwifery monthly to review their actions. The

Executive lead for the overarching action plan is the Director of Nursing & Midwifery, with the Deputy Director of Nursing & Midwifery as the operational lead. The Divisional managers are the operational managers who will be accountable for ensuring the delivery of the action plan within their divisions.

Recommendation

The Board is asked to note the warning notice, ratings, actions and findings arising from the CQC inspection approve the process for monitoring and tracking progress against actions.

Improvement plan post CQC inspection 2020

Introduction

The Trust has received the CQC Inspection report and returned the factual accuracy response. The CQC report includes 1 warning notice 16 requirements and 23 recommendations under the headings shown below:

1. Safe
2. Caring
3. Responsive
4. Effective
5. Well led

The action plan has been developed to ensure compliance with all the recommendations with in the report. It is expected that the action plan will be monitored through the Quality Committee monthly, then to Trust Board by exception.

- Executive Sponsor
- Operational Manager
- Operational Lead
- Issue Description
- Action description with responsible assurance committee
- RAG rating
- Target date for completion of the formulated action.
- Progress update

Red actions have not yet started	Amber actions are actively in progress	Green actions have been completed

2018 Outstanding actions- Recommendations

- Staff were currently using two different recording systems on the delivery unit and there were some concerns raised by staff about duplication of documentation, confusion and room for errors. Senior medical staff agreed that using two systems (electronic and paper documentation) could potentially be a cause for concern
- The information technology infrastructure was miss-matched across the trust and posed potential clinical risks. There were many systems patched together, resulting in slow systems which affected service delivery.
- Computer information systems needed to be enhanced, streamlined and developed further to reduce and mitigate risks.
- Mandatory training rates showed that compliance rates were below the trust target of 95% in three of the four main in- patient clinical areas
- Managers across the hospital did not always promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values
- Not all staff had received annual appraisal reviews.

2020 inspection

Must Do

No		Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
1	**Trust-wide** **SAFE**	Proper and safe management of medicines, including ensuring that there is a robust process in place for the monitoring of emergency medicines stored on the resuscitation trolleys to make sure that medicines do not exceed the manufacturers recommended expiry dates and are safe to use when needed. (Regulation 12 (1) (2) (g)	1. Develop and embed governance processes in all areas by ensuring area are audited monthly. 2. Quarterly audit by pharmacy of each area. 3. Monthly report to MMC with assurance to Quality Committee	DONM	Divisional Managers	DDONM		August 2020 October 2020 December 2020	
2	**Trust-wide** **SAFE**	The trust must ensure the equipment used is safe for its intended purpose and ensure all resuscitation equipment is checked regularly and there are appropriate systems to monitor compliance with this. (Regulation 12 (1) (2) (e)	1. All resuscitation equipment will be checked in line with SOP 2. Monthly report to resuscitation committee with assurance to Quality committee	DONM	Divisional Managers	DDONM		August 2020 December 2020	
3	**Trust-wide** **SAFE**	The trust must ensure that their systems and processes operate effectively across all areas of the trust to ensure that they assess, monitor and improve the quality and safety of all services provided and	1. Pathways for under 18's will be developed for each service.	DONM	Divisional Managers	DDONM		August 2020 October 2020	

		assess, monitor and mitigate the risks to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (2) (a and b)	2. Development of a trust-wide transfer policy 3. Quarterly report to safety senate on each pathway with Assurance to Quality Committee					December 2020	
4	**Trust-wide** **SAFE**	The trust must ensure that their systems and processes operate effectively across all areas of the trust to ensure that they assess, monitor and improve the quality and safety of all services provided and assess, monitor and mitigate the risks to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (2) (a and b)	1. Health and Safety COSHH risk assessments will be in place and chemicals stored appropriately. 2. Bi- Annual audits reported to Safety senate with Assurance to Quality Committee	DONM	Divisional Managers	DDONM		August 2020 December 2020	
5	**Trust-wide**	The trust must ensure that patients receive care in a timely way and work towards improving performance against national standards such as the time from diagnosis to treatment. Regulation 12 (2)	1. Waiting times will be met in line with National Standards. 2. Monthly monitoring at Access Board with Assurance to FPBD	DOP	Divisional Managers	DDOP		(Awaiting national guidance following pandemic)	
6	**Trust-wide** **EFFECTIVE**	The trust must ensure that their audit and governance systems remain effective. Regulation 17 (2)(f)	1. The Trust Audit plan will ensure all national guidance is taken account of with a Risk assessment.	MD	Divisional Managers	DMD		September 2020	

			2. Bi- Annual reports to Effectiveness senate with Assurance to Quality Committee					December 2020	
7	**Gynae/ CSS** **SAFE**	The service must ensure the proper and safe management of medicines, including ensuring that there is a robust process in place for the monitoring of emergency medicines stored on the resuscitation trolleys to make sure that medicines do not exceed the manufacturers recommended expiry dates and are safe to use when needed. (Regulation 12 (1)(2)(g)	1. Develop and embed governance processes in all areas by ensuring areas are audited monthly. 2. Quarterly audit by pharmacy of each area. 3. Monthly report to MMC with assurance to Quality Committee	DONM	Divisional Managers	DDONM		August 2020 October 2020 December 2020	
8	**Gynae/ CSS** **SAFE**	The service must ensure that patients receive care in a timely way and work towards improving performance against national standards such as the time from diagnosis to treatment. Regulation 12 (2)	1. Waiting times will be met in line with National Standards. 2. Benchmark with other TOP services and provide a report to effectiveness senate with Assurance to Quality Committee. 3. Monthly monitoring of waiting times at Access Board with Assurance to FPBD	DOP	Divisional Managers	DDOP		(Awaiting national guidance following pandemic) September 2020 December 2020	
9	**Gynae** **EFFECTIVE**	The service must ensure they have enough staff with the right qualifications, skills, training and experience to keep	1. Training needs analysis will be undertaken. 2. Competencies will be developed for the Nursing team.	DONM	Divisional Managers	DDONM		September 2020 October 2020	

		patients safe from avoidable harm and to provide the right care and treatment on the ward. Regulation 18(1)(2)(a)	Identified timeframes with Assurance at PPF 3. Medical staff will be appointed					December 2020	
10	**Gynae** **SAFE**	The service must ensure that there is a system in place to manage the deterioration of a poorly young person between the age of 16 and 18 years old. Regulation 12(1)(2) (c	1. Pathways for under 18's will be developed for each service. 2. An escalation policy will be developed for the deterioration of people under 18 3. Quarterly report to safety senate on each pathway with Assurance to Quality Committee	DONM	Divisional Managers	DDONM		August 2020 October 2020 December 2020	
11	**Gynae** **EFFECTIVE**	The service must ensure staff looking after young people have the right qualifications, skills, training and experience to keep them safe from avoidable harm. Regulation 12 (2) (c)	1. Review of national guidance and what training/ requirements are in scope 2. Training needs analysis will be undertaken. 3. Competencies required for the Nursing team. Identified	DONM	Divisional Managers	DDONM		August 2020 September 2020 December 2020	

			timeframes with Assurance at PPF.						
12	**Gynae** **WELL-LED**	The provider must ensure leaders of the service are familiar with and understand the risks to the service.	1. Education of all staff will be undertaken of the risk register and risks associated with the service. 2. Knowledge and understanding of this will be checked monthly and reported to Divisional Board with Assurance at Quality Committee	DONM	Divisional Managers	DDONM		August 2020 September 2020	
13	**Neo-nates** **SAFE**	The service must ensure the proper and safe management of medicines, including ensuring that there is a robust process in place for the monitoring of emergency medicines stored on the resuscitation trolleys to make sure that medicines do not exceed the manufacturers recommended expiry dates and are safe to use when needed. (Regulation 12 (1) (2) (g) (e)	1. Develop and embed governance processes in all areas by ensuring area are audited monthly. 2. Monthly checks by resus officers with a report to resus committee quarterly with Assurance to Quality committee 3. Quarterly audit by pharmacy of each area. 4. Monthly report to MMC with assurance to Quality Committee	DONM	Divisional Managers	DDONM		August 2020 December 2020 October 2020 December 2020	

14	**Maternity** **SAFE**	The service must ensure the proper and safe management of medicines, including the proper storage of medicines (Regulation 12 (1) (2) (g)	1. Develop and embed governance processes in all areas by ensuring area are audited monthly. 2. Quarterly audit by pharmacy of each area. 3. Monthly report to MMC with assurance to Quality Committee	DONM	Divisional Managers	DDONM		August 2020 October 2020 December 2020	
15	**Maternity** **SAFE**	The service must ensure the equipment used is safe for its intended purpose and ensure all resuscitation equipment is checked regularly and there are appropriate systems to monitor compliance with this. (Regulation 12 (1) (2) (e)	1. All resuscitation equipment will be checked in line with SOP 2. Monthly audit report to resuscitation committee with assurance to Quality committee .	DONM	Divisional Managers	DDONM		August 2020 December 2020	

Should do

No		Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
16	**Gynae**	The provider should ensure there is appropriate tool to assess pain.	1. Pain assessment tool will be developed, implemented and audited. 2. Quarterly audits reported to Effectiveness senate with assurance to Quality committee	DONM	Divisional Manager	DDONM		June 2020	
17	**Gynae**	The provider should ensure all staff complete their mandatory training.	1. All staff to complete their mandatory training within an agreed trajectory. 2. Quarterly reports with assurance to PPF	DONM	Divisional Manager	DDONM		June 2020 December 2020	
18	**Gynae**	The provider should ensure all staff complete their safeguarding training.	1. All staff to complete their safeguarding training within an agreed trajectory 2. Quarterly reports with assurance to PPF	DONM	Divisional Manager	DDONM		June 2020 December 2020	
19	**Gynae**	The provider should ensure they have a vision in place which is underpinned with values and a strategy	1. The Trust vision/values and strategy needs to be embedded across the services	DONM	Divisional Managers	DDONM		September 2020	

			and services need to align their own strategy to this 2. Monthly reports to Divisional Board with Assurance at PPF quarterly					December 2020	
20	**Gynae**	The provider should ensure they support the needs of dementia patients or patients with any other protected characteristics.	1. Pathways for patients with protected characteristics will be developed. 2. Audit of pathway to be completed with report to patient experience committee with assurance to Quality Committee.	DONM	Divisional Managers	DDONM		September 2020 December 2020	
21	**Gynae**	The provider should ensure the leadership structure is stabilised.	1. Divisional leadership and ward leadership will be developed and stabilised. .	DONM	Divisional Managers	DDONM		September 2020	
22	**Neo-nates**	The service should consider implementing a staffing board on the low dependency unit so that it is visible to the public.	1. Staffing board will be placed on the low dependency unit	DONM	Divisional Managers	DDONM		July 2020	
23	**Neo-Nates**	The service should ensure that cleaning products which are hazardous to health are consistently stored securely to prevent potential risk to patients and visitors in line with national patient safety alert requirements. Regulation	1. Health and Safety COSHH risk assessments will be in place and chemicals stored appropriately. 2. Bi- Annual audits reported to Safety senate with Assurance to Quality Committee	DONM	Divisional Managers	DDONM		September 2020	

		12(2)(b)							
24	**Neo-Nates**	The service should consider a review of its governance processes for the monitoring of daily resuscitation equipment checks to make sure that equipment is safe and ready for use. Regulation 12(1) (2) (e	1. All resuscitation equipment will be checked in line with SOP 2. Monthly audit report to resuscitation committee with assurance to Quality committee	DONM	Divisional Managers	DDONM		August 2020 December 2020	
25	**Neo-nates**	The service should consider a review of the arrangements for the storage of emergency equipment so that it is clear to staff what should be included, so that missing sundries can be easily identified during the regular checks. Regulation 12(1) (2) (e	1. All resuscitation equipment will be checked in line with SOP 2. Monthly audit report to resuscitation committee with assurance to Quality committee	DONM	Divisional Manager	DDONM		August 2020 December 2020	
26	**Neo-nates**	The service should ensure that medicines related stationery is stored securely and cannot be accessed by unauthorised persons	1. All medicines related stationery will be kept in a secure place and only accessed by authorised personnel 2. Develop and embed governance processes in all areas by ensuring area are audited monthly.	DONM	Divisional Managers	DDONM		May 2020 August 2020 October 2020	

			3. Quarterly audit by pharmacy of each area. 4. Monthly report to MMC with assurance to Quality Committee					December 2020	
27	**Neo-nates**	The service should consider a review of the monitoring process for the recording of medication storage temperatures so that documentation reflects action staff have taken when temperatures have exceeded the maximum range.	1. Develop and embed governance processes in all areas by ensuring areas are audited monthly 2. Monthly report to MMC with assurance to Quality Committee	DONM	Divisional Managers	DDONM		September 2020 December 2020	
28	**Neo-nates**	The service should consider a review of its guidelines and policies so that expected review dates are clearly visible to staff.	1. All guidelines and policies to include review dates. 2. Ensure education of all staff on the policies. 3. Knowledge and understanding of this will be checked monthly and reported to Divisional Board with Assurance at Quality Committee	DONM	Divisional Managers	DDONM		September 2020 September 2020 November 2020	

29	**Neo-nates**	The service should consider a review of the information available to parents and their families on the units so that it can be requested it in alternative formats or languages to meet their needs.	1. The information that is available to parents and their family's will be stated clearly that it can be requested in alternative languages and formats	DONM	Divisional Managers	DDONM		July 2020	

Liverpool Women's NHS Foundation Trust

Agenda Item

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**2019 Staff Survey Results**
DATE OF MEETING:	Thursday, 07 May 2020
ACTION REQUIRED	**Approve**
EXECUTIVE DIRECTOR:	Michelle Turner, Director of Workforce and Marketing
AUTHOR(S):	Rachel London, Deputy Director of Workforce
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 are requested to note the content and approve proposed actions.**			
PREVIOUSLY CONSIDERED BY:	**Committee name**		***Choose an item.*** Or type here if not on list: ***Click here to enter text.***	
	Date of meeting		***Click here to enter a date.***	

Executive Summary

The paper provides an overview of the Staff Survey results for 2019. It highlights that the key theme scores have remained stable, with positive increases in two of the eleven themes, and no decreases. Importantly, the key overall staff engagement score increased from 7.0 to 7.2, the largest increase since 2015.

The results have been broken down and shared with management teams, to be used in reviewing, revising and instigating actions throughout the Trust.

Report

1. Introduction

The 2019 National Staff Survey was conducted from September to December 2019, with the results being published nationally in February 2020. The survey is carried out by all NHS organisations using a nationally agreed set of questions. As in previous years, the Trust surveyed all its staff rather than just the required minimum sample, and the survey was undertaken by Quality Health, one of the DoH approved contractors.

We maintained our traditionally high response rate, achieving 61% in 2019. By comparison, the average for other acute specialist Trusts was 58%, and the average across the whole NHS was just 48%. For the first time, the Trust trialled using an electronic survey in most corporate and admin areas.

As in previous years, our comparator group is 'specialist acute Trusts' and we are compared against these organisations, despite the majority of our services being akin to an acute Trust.

The survey itself contains a total of 31 questions, many with multiple parts, but for the nationally published results, these are statistically analysed grouped & weighted, and presented as eleven key themes: equality diversity & inclusion, health & wellbeing, immediate managers, morale, quality of appraisals, quality of care, safe environment (bullying & harassment), safe environment (violence), safety culture, staff engagement, and team working. The results are shown as a score out of ten for each theme.

2. National Picture

The headlines from the national results for the NHS as a whole were as follows:

- five of the eleven key themes showed improvement, particularly the people management elements: support from immediate managers, morale, quality of appraisal, quality of care and safety culture
- nationally there was no improvement on bullying and harassment scores
- the equalities gap widened for BME staff on key issues, but did show some progress on perceptions
- health & wellbeing and staff engagement figure remained stable
- staff engagement was also stable overall, although 82 trusts did show an improvement of one point or more

These were the key messages shared at the NHS Staff Survey and Staff Engagement "Share and Learn" 2020 event held on 12th March, hosted by NHS Employers.

3. Our Trust's Results

a. Headlines

- we improved compared to last year in two overall 'themes' – *safety*, and *staff engagement*
- we did not see a statistically significant decline in any of the eleven overall themes – this is very much in line with the national picture where overall, the results were largely 'stable'
- our results compare positively to our comparators (specialist acute trusts) in the themes of *equality & diversity, health & wellbeing, and bullying & harassment*
- we saw positive increases in lots of individual questions relating to Immediate Management including questions about my manager 'values my work' , 'involves me in change', and 'encourages me at work'
- there were positive increases in staff recommending the Trust as a *place for care* and as *a place to work,* although these remain lower than for other specialist acute trusts
- there was a positive decrease in *intention to leave organisation*
- there was a significant positive decrease in relation to *bullying & harassment from managers*
- we saw positive increases in all questions relating to *safety culture*, including incident reporting, receiving feedback, and the organisation takes action
- there were a small number of specific questions where our results had declined, although not by enough to be statistically significant as a theme – these included:
    - the organisation makes a positive impact on health and wellbeing
    - quality of PDR

A summary table (extracted from the Trust's nationally published report) is included as appendix 1. This shows comparisons for each theme with the best, worst and average scores in our comparison group (acute specialist trusts).

b. Theme Scores

i. Equality, Diversity & Inclusion
Although there was a minor drop from 9.5 in 2018 to 9.4 in 2019 (not statistically significant), this is still comfortably above the national average for our comparison group of 9.2.

ii. **Health & Wellbeing**
There was a minor increase from 6.3 to 6.4 (not statistically significant) which is now above the national average of 6.3. For the specific question regarding whether staff have felt unwell as a result of work related stress, the Trust figure of 32.2% in considerably lower than the national average for acute specialist Trusts of 36.6%.

iii. Immediate Managers
There was a minor increase from 6.8 to 6.9 (not statistically significant) although this remains slightly below the national average of 7.1. It is encouraging that for the six questions that make up this theme, all saw improvements from our 2018 scores.

iv. Morale
This figure increased from 6.1 to 6.3 (not statistically significant), which is now just below the national average of 6.4. It is notable that the specific question regarding involving staff in deciding changes that affect them saw an increase from 49.5% in 2018 to 57.2% in 2019. It should also be noted that the three questions regarding any intention to leave the Trust all saw improved scores.

v. Quality of Appraisals
This figure remained unchanged from the previous year at 5.2. This is significantly below the national average which rose to 5.8. The specific question scores were mixed for this theme, although the score for the question asking if the appraisal left the employee feeling that their work is valued by the organisation increased from 25.9% to 28.1%.

vi. Quality of Care
This score increased from 7.5 in 2018 to 7.6 in 2019 (not statistically significant), while the national average remained unchanged at 7.9. The score for the specific question regarding staff being able to deliver the care they aspire to rose from70.7% in 2018 to 74.0% in 2019.

vii. Safe Environment - Bullying & Harassment
This score increased from 8.6 to 8.7 (not statistically significant), which is markedly better than the national average of 8.3, and matches the best score nationally for acute specialist trusts. In particular, the score for the specific question regarding bullying by managers fell from 10.9% in 2018 to 7.9% in 2019 (having previously fallen from 15.5% in 2017).

viii. Safe Environment - Violence
Our score remained unchanged at 9.9. This is better than the national average of 9.8, and matched the best score in our comparison group.

ix. Safety Culture

This score increased from 6.7 to 6.9 and is now just 0.1 off the national average score of 7.0. Of particular note, the specific question concerning the Trust treating staff who are involved in incidents & near misses fairly saw an improvement from 50.5% in 2018 to 58.5% in 2019, and the number of staff said they would feel secure in raising concerns rose from 69.1% to 73.3%.

x. Staff Engagement

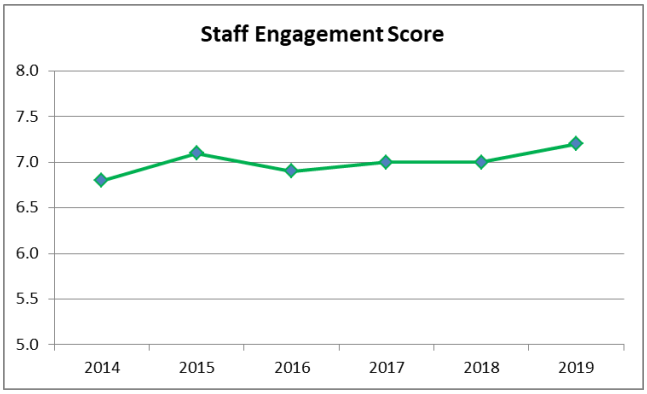
Our score increased from 7.0 in 2018 to 7.2 2019, although this is still below the national average of 7.5. Nevertheless, all nine questions that constitute this theme saw improvements.

xi. Team Working

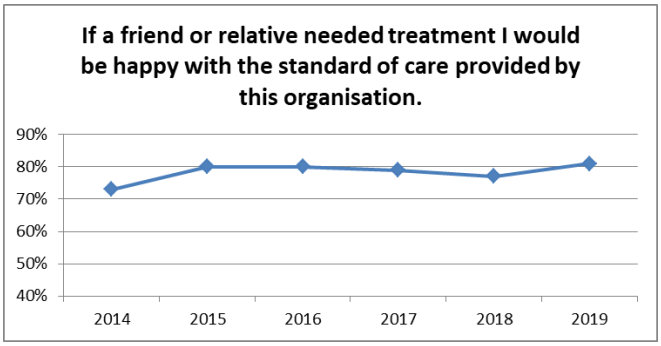
Our score remained unchanged at 6.6, as did the national average at 6.9. There were no significant changes in the scores for either of the specific questions that make up this theme.

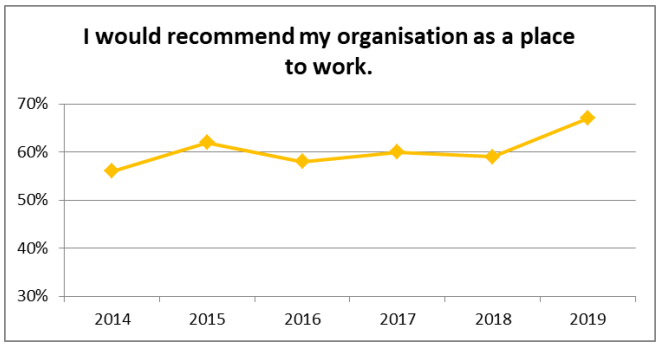
c. Longer Term Trends

Looking back over the results from the previous five year's surveys, this year's increase in the staff engagement score reflects a positive trend dating from 2016:



It should also be noted that the scores for staff recommending the Trust as both a *place to receive treatment*, and as *a place to work*, reversed the fall in both these scores seen in the previous year. The significant rise in the score for recommending the Trust as a place to work is particularly encouraging:





d. Listening Event

On 5th February 2020, we held a listening event with staff to discuss and review the staff survey results. The event used an appreciative enquiry approach to explore as a Trust a number of key themes. Each table had a facilitator and was focused on a specific issue: health and wellbeing, bullying and harassment, learning from errors, engagement and communication, and support from immediate managers. Participants included staff from across all parts of the Trust, including the Chair, Chief Executive and members of the board as well as a number of senior medical staff. All the staff attending

had the chance to participate in the discussions at each table. A considerable amount of feedback was produced through this event, and outlined below are some of the key messages:

- Staff welcomed the opportunity to speak freely away from the workplace with very senior leaders
- Personal perception of Bullying & Harassment
- More communication regarding MHFA/DAW
- Leadership/manager training
- Communication of outcomes of bullying incidents
- Drop in sessions for Bullying and Harassment
- Bring HWB to us
- Fruit & Veg Van more frequent
- HWB App
- 'Be Kind' message
- Managers to recognise breaks
- Debrief after shifts for wellbeing
- Food availability for out of hours staff
- Staff Rotation for more experience in other areas
- Workforce Council
- Constructive, positive and widely shared learning from incidents
- More 'Lessons Learned'
- Open area on intranet for sharing of outcomes so we can learn more
- Scenarios for Multi-professional training
- Promote positive themes
- Lesson of the week on Social Media
- Improve feedback to staff following incidents
- What a good manager looks like – share this
- What went well after shift
- Opportunities for shadowing managers
- Communication
- Difference in Leadership & Management
- Talent in teams
- Change Management
- Being valued
- Feedback Locally on errors

This information will now be disseminated across the senior management teams throughout the Trust, to help inform the formation of their action plans.

4. Moving Forward

Local results have been drilled down to division, directorate and ward/department level, and summaries have been distributed to the divisional management teams. They have been tasked with identifying key actions for their areas which will be signed off and monitored through the divisional board meeting. The local summaries also include a simple "you said /we did" pro-forma for local managers to use in sharing the results with their staff.

The results will also be used to refine and enhance the Putting people First Strategy Year 2 Action Plan.

There will clearly be ongoing and sustained challenges in relation to engagement and motivation within the workforce in light of the Covid-19 pandemic, and our workforce strategy must responsive to the current needs of our staff. It is likely that the staff survey will be cancelled for 2020, the Trust will continue with implementation of a new online and paper based local survey system in Summer 2020, circumstances permitting. We will also take forward learning from the changes made during Covid-19, which are likely to include more agile working, and a more flexible approach to staff support, learning and engagement, delivering bite size training to staff in their place of work.

5. Conclusions

The results of the staff survey demonstrate some important improvements, and a consolidation of previous year's results. The consolidated improvement in our staff engagement score is particularly encouraging. The

results also highlight differences between departments and staff groups, which will be used to focus and inform the actions to be taken across the Trust, both in terms of the continuing implementation of the Putting People First Strategy, and in further improving our staff survey results across the board.

Impact on the BAF risk

The Putting People First Committee recommended a reduction of the BAF risk as follows:

The current BAF risk for staff engagement 2293 '*Staff are not motivated, engaged or effective in delivering the vision, values and aims of the Trust*' is currently scored as 10 (impact = 5, likelihood = 2). The target score is 10. Given the consistent improvement in the engagement score since 2016, it is proposed that the risk score is revised.

The proposed risk score is 8 (impact = 4' Major', likelihood = 2 'unlikely').

The reduction of the consequence risk score is in line with guidance from the National Patient Safety Agency who provide the following examples for a 'Major- 4' HR risk

- Uncertain delivery of key objectives due to lack of staff
- Unsafe staff levels or competence (< 5days)
- Very low staff morale
- No staff attendance for mandatory training.

The Board will be requested to approve this change under the BAF agenda item.

6. Recommendations

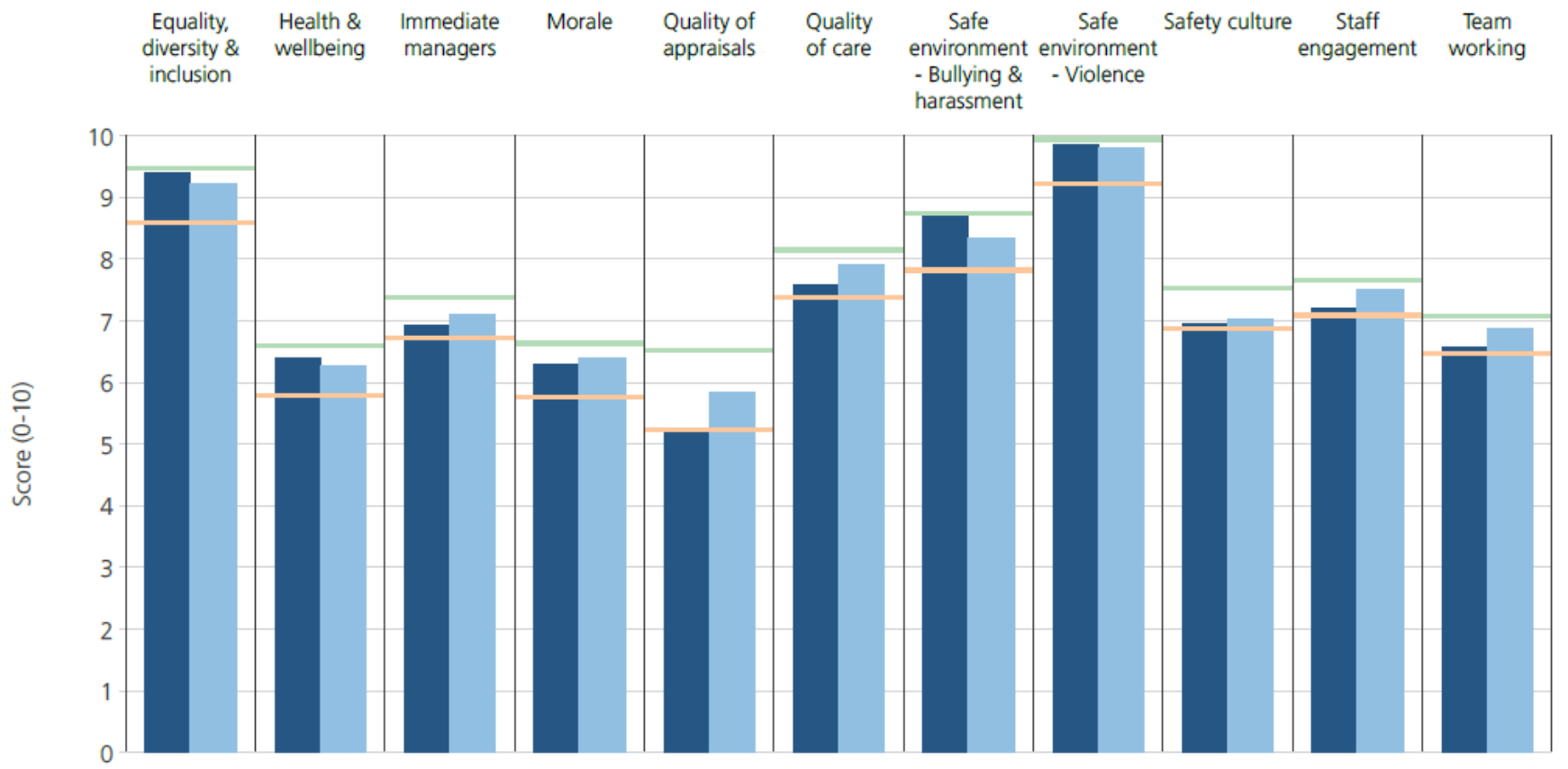
The Board are requested to note the content and approve proposed actions.

appendix 1

Survey Coordination Centre

2019 NHS Staff Survey Results > Theme results > Overview

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.6	7.4	6.6	6.5	8.1	8.7	9.9	7.5	7.7	7.1
Your org	9.4	6.4	6.9	6.3	5.2	7.6	8.7	9.9	6.9	7.2	6.6
Average	9.2	6.3	7.1	6.4	5.8	7.9	8.3	9.8	7.0	7.5	6.9
Worst	8.6	5.8	6.7	5.8	5.2	7.4	7.8	9.2	6.9	7.1	6.5
Responses	822	830	826	814	748	746	819	822	826	831	816

Liverpool Women's NHS Foundation Trust

Agenda Item

MEETING	**Trust Board Meeting**
PAPER/REPORT TITLE:	**Review of 2019/20 Flu Vaccination Campaign & Planning for the 2020/21 Campaign**
DATE OF MEETING:	Thursday, 07 May 2020
ACTION REQUIRED	**Assurance**
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*** ☐

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 are asked to accept the assurance regarding the assessment of the 2019/20 campaign, and endorse the proposed planning for the forthcoming 2020/21 campaign.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		*Choose an item.* Or type here if not on list: *Click here to enter text.*	
	Date of meeting		*Click here to enter a date.*	

Executive Summary

The 2019/20 flu staff vaccination campaign has now been successfully completed with the Trust meeting the CQUIN target of 80% of frontline staff being vaccinated, achieving a final figure of 81%. This represented 877 frontline staff being vaccinated, and we also managed to vaccinate a further 125 non clinical staff.

Preparation for the 2020/21 needs to start in July/August 2020, and suggestions are included in section four of this paper to support achievement of the CQUIN target which has now been further increased to 90% of frontline staff.

Report

1) Introduction

The purpose of this paper is to give assurance that the CQUIN targets in relation to the flu vaccination campaign have been met for 2019/20, to review the effectiveness of the campaign, and to put forward planning ideas for the 2020/21 campaign.

2) Results of the 2019/20 Flu Vaccination Campaign

For 2019/20, the CQUIN requirements for staff flu vaccinations was as follows:

"Achieving an 80% uptake of flu vaccinations by frontline clinical staff:

- In Q1 Provider will submit a report to commissioners detailing lessons from the 2018/19 flu campaign highlighting what went well, what didn't go so well and what learning will be taken forward into the 2019/20 campaign.
- In Q2 Provider will submit a report and action plan to commissioners detailing the organisations communications and engagement plan for the forthcoming campaign and the action plan that has been developed to support the programme including timescales.
- In Q3 the Provider will make a monthly data submission to PHE via ImmForm. No submission is required to the CCG in Q3.

- In Q4 the Provider will make a monthly data submission to PHE plus submit a report to the CCG detailing the final uptake rate and details of the monthly submissions."

All these requirements were met, with the final figures for the flu vaccination campaign as follows:

	Doctors	Nurses & Midwives	AHP	Support Staff	Total Frontline	Other (non frontline)
number of staff	114	686	65	218	1083	307
number vaccinated	114	493	65	205	877	125
% vaccinated	100.0%	71.9%	100.0%	94.0%	81.0%	40.7%

Consequently, the full amount of £291,593 in CQUIN funding (£72,898 is allocated to each quarter) will be achieved.

It should be noted that for 2020/21, the CQUIN target figure has been increased again to 90% of frontline staff being vaccinated.

3) Review of the 2019/20 Flu Vaccination Campaign

As in previous years, the flu campaign was co-ordinated and undertaken by the Occupational Health Department as part of the service that we contracted from Aintree University Hospitals (now part of Liverpool University Hospitals Foundation Trust). They provided a range of drop in sessions and targeted visits to specific departments (including night staff) to ensure that the vaccination was available to all frontline staff, and where possible to all staff across the Trust. This was augmented by the use of peer vaccinators, nine of whom were trained and deployed across the Trust.

Perhaps the biggest challenge faced was in the supply of the vaccines. Although these had been ordered in plenty of time, there was a worldwide shortage of vaccines which meant that delivery was in stages, and consequently the Trust quickly ran out of vaccines (as did all other local Trusts and many nationwide) which led to a hiatus of several weeks and a stalling of the initial momentum of the campaign. Although sufficient stocks were eventually received and the 80% target was achieved, this undoubtedly had a negative impact on the effectiveness of the 2019/20 campaign.

Reviewing the 2019/20 campaign, the positive aspects included:

- The Trust once again worked closely with our occupational health providers who provided an effective and comprehensive vaccination programme across the Trust.
- The wider use of peer vaccinators was particularly effective in catching those staff who were unable to be vaccinated during the sessions organised by occupational health because of their rotas, annual leave, sickness etc.
- As In previous years, there was top level buy-in and support for the campaign from the board and senior managers across the Trust.
- Ultimately, the CQUIN target of having at least 80% of frontline staff vaccinated was achieved.

Issues that were more challenging included:

- A 'virtual' e-mail group was set up to oversee the campaign, but perhaps wasn't as effective as a more formal group could have been, for example in dealing with the issues resulting from the shortage of vaccines.
- The training of peer vaccinators could have been planned and delivered earlier in the year.
- We still struggled to offer enough coverage to those staff away from the main Crown Street site such as community midwives, the HFC at Knutsford etc.

4) Proposed Planning for the 2020/21 Flu Vaccination Campaign

For the 2020/21 campaign, it is proposed to:

- Identify 'flu champions' in each ward and department to provide a local focus for communications and encouraging all staff to be vaccinated.

- Establish a formal group to plan and co-ordinate the campaign. This would be chaired by the Trust lead from the HR department and include representatives from occupational health, communications and senior N&M management, together with 'champions' from each main area across the Trust. Ideally, the group would meet from July 2020 onwards.

- Identify a broader range of staff to be trained as peer vaccinators. This could include senior N&M managers from across the Trust, those N&M staff who have a visible presence across the Trust such as the PEFs, and at least one member of staff from each ward and department. This would also include staff from those areas off site including the community midwives and the HFC in Knutsford. The plan would be to schedule this training for August 2020.

- Produce a Q&A sheet for staff explaining the benefits of vaccination, busting some of the myths about flu vaccination, and highlighting all the ways that staff can access vaccinations eg) publishing the occupational health sessions, who the peer vaccinators are and how to contact them, and the fact that if staff receive their vaccination from their GP or from some other source, this can still be counted towards the Trust's figures.

- A more formal communications plan to include posters, screen savers, weekly digest articles, twitter feed etc. starting from August 2020 onwards and running throughout the flu campaign.

- As in previous years, support from the board will be fundamental to the success of the campaign in terms of:
    - a public commitment to aiming to vaccinate 100% of all our staff, both front-line and non-clinical
    - support in encouraging managers to free staff up to be 'flu champions' for their areas and to be peer vaccinators
    - leading by example eg) photographs of the board (and other senior managers) being vaccinated included in regular communications sends out a powerful message to staff.

Of course the planning and execution of the 2020/21 flu vaccination campaign will be dependent on the national situation in relation to the Covid 19 pandemic, and the situation will need to be reviewed and re-evaluated nearer the time, preferably at the beginning of August 2020.

It should be noted that the vaccines for the 2020/21 have already been ordered by the Occupational Health Department on behalf of the Trust.

5) Recommendations

The Board are asked to accept the assurance given in the report with regards to the success of the 2019/20 Flu Staff Vaccination Campaign, and endorse the proposed planning for the 2020/21 Flu Staff Vaccination Campaign.

Liverpool Women's NHS Foundation Trust

	Agenda Item
MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Performance Report**
DATE OF MEETING:	Thursday, 07 May 2020
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):	*Choose an item.*	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The committee is asked to note the report***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	*Choose an item.* Or type here if not on list: *Click here to enter text.*
	Date of meeting	*Click here to enter a date.*

Executive Summary

This report has been produced to provide a performance position against the Trusts key access standards and outline the measures being undertaken to improve performance where required by exception.

Month 12 began to see some of the effects of the Covid 19 pandemic on operational performance

Report

1. Introduction

This report provides an overview of the Trust's performance against the key access standards highlighting those where the targets have not been met in month and subsequent actions taken to improve this position.

2. Workforce

KPI ID	Source	Service	Target < or >	Target	Value	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Sickness Absence Rate	**Owner - Deputy Director of Workforce**																	
KPI101T	NHSI	Trust	<=	4.5%	Numerator		2162	2083	1700	2041	2321	1989	2499	2264	2532	2549	2229	3195
					Denominator		39457	41042	39805	41056	39241	38077	40070	39330	40809	40902	38492	41197
					Performance		5.48%	5.07%	4.27%	4.97%	5.92%	5.22%	6.24%	5.76%	6.21%	6.23%	5.79%	7.75%
					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%
					Qtrly Performance		4.94%	4.94%	4.94%	5.37%	5.37%	5.37%	6.07%	6.07%	6.07%	6.61%	6.61%	6.61%
Mandatory Training Compliance	**Owner - Deputy Director of Workforce**																	
KPI095T	Quality Strategy	Trust	>=	95.0%	Numerator													
					Denominator													
					Performance		85.00%	86.00%	88.00%	89.00%	89.00%	90.00%	90.00%	89.00%	91.00%	91.00%	91.00%	91.00%
					Trend		▼	▲	▲	▲	▶	▲	▶	▼	▲	▶	▶	▶
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance													

Sickness absence reduced slightly in February however began to see a significant rise in March related to Covid 19 which will rise further. It is anticipated that sickness absence will remain high during the pandemic. There is significant work ongoing for all staff who are affected by Covid 19 associations. It is equally important that the work continues to support staff who are off with non Covid 19 related issues.

3 Experience

3.1 Access standards

INDICATOR		METRIC	THRESHOLD		ACTUALS											
					Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Cancer	2WW for suspected cancer	%	≥93%	Higher values are better	94.2	97.7	93.3	95.0	*93.9*	*96.3*	*97.9*	*96.7*	*95*	*92.58*	*96.7*	*94.5*
	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*	*60.0*	*85.1*	*70.0*	*78.4*	*81.8*	*72.2*
	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*	*22.7*	*47.1*	*37.0*	*44.4*	*39.1*	*63.0*
	104d Referral to First Definitive Treatment	Count	0	Zero tolerance	0	1	3	0	*1*	*7*	*2*	*1*	*5*	*2*	*5*	*3*
RTT	RTT Incomplete Pathways <18 weeks	%	≥92%	Higher values are better	84.6	83.0	81.5	81.95	*83.0*	*83.3*	*83.1*	*83.7*	*82.00*	*82.60*	*81.00*	*79.00*
	Incomplete Pathway > 52 Weeks	Count	0	Zero tolerance	6	3	3	1	*1*	*1*	*3*	*5*	*1*	*0*	*0*	*0*

Cancer: for all Trusts data every month is submitted to the national data base (CWT) 5 weeks after the month end to ensure the accurate reallocation of the breaches. Data shown in grey is the **unvalidated** position and subject to change due to on-going data validation Trends therefore cannot incorporate or reflect the March data until the formal submissions are made.

RTT: All Trusts release the RTT data to the CCG at the end of the third week of the month for scrutiny with final upload to NHSE when this is then released publicly by the end of that month. Dates will vary according to calendar month and months with a bank holiday in them.

Cancer

Cancer performance remains a significant concern for the Trust with long term sickness within the speciality and vacancy. The 2-week target is on track to achieve as required for the quarter. The 31-day and 62-day target were not achieved.

The service has a medical establishment of 6 sub-speciality oncologists. At present there are 3 Consultants in post and due to sickness 2 undertaking clinical duties. 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.

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.

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. This proposes to move to a system level cancer improvement plan.

During the Covid 19 Pandemic the Trust will be the lead for Gynaecology Cancer for Cheshire and Merseyside.

RTT

RTT incomplete 18-week pathway performance was 79% for March which as a decrease. There were no 52-week breeches. Routine and elective non urgent appointments and surgery have been nationally postponed due to the Covid 19 pandemic.

The service is currently risk stratifying new and follow up patients to ensure correct prioritization when national instruction allows the restart and recovery of this work.

3.2 Unplanned reattendance

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
A&E: Unplanned Reattendances within 7 days (Non Pregnancy Related)					Owner - Head of Nursing Gynaecology													
KPI014	Quality Schedule	Gynaecology	<=	7.0%	Numerator		20	32	28	30	23	19	36	28	19	32	21	35
					Denominator		350	375	340	375	349	304	391	341	275	355	371	263
					Performance		5.71%	8.53%	8.24%	8.00%	6.59%	6.25%	9.21%	8.21%	6.91%	9.01%	5.66%	13.31%
					Trend		▼	▲	▼	▼	▼	▼	▲	▼	▼	▲	▼	▲
					Target %		7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%
					Qtrly Performance		7.51%	7.51%	7.51%	7.00%	7.00%	7.00%	8.24%	8.24%	8.24%	8.90%	8.90%	8.90%

The unplanned reattendance rate reduced in February significantly following work to increase specialist urgent clinics. March figures began to show an increase related to Covid 19 pressures as patients were brought back to be seen in advance of service changes to ED.

3.3 Cancellations of surgery

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
TCI: % Cancelled by Hospital for Non-clinical Reasons					Owner - Divisional Manager Gynaecology													
KPI202	Trust Objectives	Gynaecology	<=	4.0%	Numerator		27	33	43	56	38	44	60	45	55	78	54	155
					Denominator		818	807	797	878	884	823	905	906	684	816	644	532
					Performance		3.30%	4.09%	5.40%	6.38%	4.30%	5.35%	6.63%	4.97%	8.04%	9.56%	8.39%	29.14%
					Trend		▼	▲	▲	▲	▼	▲	▲	▼	▲	▲	▼	▲
					Target %		4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
					Qtrly Performance		4.25%	4.25%	4.25%	5.34%	5.34%	5.34%	6.41%	6.41%	6.41%	14.41%	14.41%	14.41%

The increase in cancellations of surgery were related to unplanned Covid 19 pressures. This trend will continue due to national instruction to pause routine elective surgery. All patients are clinically risk stratified to ensure that if the condition is likely to become acute then measures are in place to address this.

4 Conclusion

This paper highlights the key access performance metrics where there is challenge in achievement and outlines the steps taken to address improvement.

Liverpool Women's NHS Foundation Trust

Board Performance Report

Published Month - April 2020

Data Included - Up to March 2020

Workforce

KPI ID	Source	Service	Target < or >	Target	Value	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Sickness Absence Rate	**Owner - Deputy Director of Workforce**																	
KPI101T	NHSI	Trust	<=	4.5%	Numerator		2162	2083	1700	2041	2321	1989	2499	2264	2532	2549	2229	3195
					Denominator		39457	41042	39805	41056	39241	38077	40070	39330	40809	40902	38492	41197
					Performance		5.48%	5.07%	4.27%	4.97%	5.92%	5.22%	6.24%	5.76%	6.21%	6.23%	5.79%	7.75%
					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%
					Qtrly Performance		4.94%	4.94%	4.94%	5.37%	5.37%	5.37%	6.07%	6.07%	6.07%	6.61%	6.61%	6.61%
Mandatory Training Compliance	**Owner - Deputy Director of Workforce**																	
KPI095T	Quality Strategy	Trust	>=	95.0%	Numerator													
					Denominator													
					Performance		85.00%	86.00%	88.00%	89.00%	89.00%	90.00%	90.00%	89.00%	91.00%	91.00%	91.00%	91.00%
					Trend		▼	▲	▲	▲	▶	▲	▶	▼	▲	▶	▶	▶
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance													

Efficient

KPI ID	Source	Service	Target < or >	Target	Value	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
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
					Trend		▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶
					Target Value		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

Liverpool Women's NHS Foundation Trust

Safety

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Never Events	**Owner - Head of Governance**																	
KPI181T	NHSI	Trust	=	0	Performance Value		0	0	0	0	0	1	0	0	0	0	0	0
					Trend		▶	▶	▶	▶	▶	▲	▼	▶	▶	▶	▶	▶
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		0	0	0	1	1	1	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
					Qtrly Performance Value		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
					Trend		▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶
					Target Value		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
Infection Control: MRSA	**Owner - Infection Control Lead**																	
KPI105T	Quality Schedule	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
					Qtrly Performance Value		1	1	1	0	0	0	0	0	0	0	0	0
Neonatal Deaths (All Live Births within 28 Days) - all booked births	**Owner - Clinical Director Neonates**																	
KPI168a	Trust Objectives	Neonates	<=	4.6%	Numerator		1	2	2	0	0	5	1	1	1			
					Denominator		649	659	662	692	699	689	696	574	655			
					Performance		0.15%	0.30%	0.30%	0.00%	0.00%	0.73%	0.14%	0.17%	0.15%			
					Trend		▲	▲	▼	▼	▶	▲	▼	▲	▼			
					Target %		4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%
					Qtrly Performance		0.25%	0.25%	0.25%	0.24%	0.24%	0.24%	0.16%	0.16%	0.16%			
Neonatal Deaths (All Live Births within 28 Days) - all live births	**Owner - Clinical Director Neonates**																	
KPI168b	Trust Objectives	Neonates	<=	6.1%	Numerator		1	4	2	0	0	5	1	3	2			
					Denominator		656	673	668	699	753	698	699	580	662			
					Performance		0.15%	0.59%	0.30%	0.00%	0.00%	0.72%	0.14%	0.52%	0.30%			
					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%
					Qtrly Performance		0.35%	0.35%	0.35%	0.23%	0.23%	0.23%	0.31%	0.31%	0.31%			

Effective

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Intensive Care Transfers Out	**Owner - Clinical Director Gynaecology**																	
KPI107T	Trust Objectives	Trust			Performance Value		1	2	0	2	0	2	1	2	1	0	0	0
					Trend		▲	▲	▼	▲	▼	▲	▼	▲	▼	▼	▶	▶
					Target Value													
					Qtrly Performance Value		3	3	3	4	4	4	4	4	4	0	0	0

Liverpool Women's NHS Foundation Trust

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
18 Week RTT: Incomplete Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI003T	NHSI	Trust	>=	92.0%	Numerator		4881	4973	5033	5117	5307	5310	5324	5224	4971	5187	5152	5149
					Denominator		5769	5990	6173	6244	6396	6377	6405	6243	6061	6283	6349	6476
					Performance		84.61%	83.02%	81.53%	81.95%	82.97%	83.27%	83.12%	83.68%	82.02%	82.56%	81.15%	79.51%
					Trend		▼	▼	▼	▲	▲	▲	▼	▲	▼	▲	▼	▼
					Target %		92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
					Qtrly Performance		83.02%	83.02%	83.02%	82.74%	82.74%	82.74%	82.95%	82.95%	82.95%	81.06%	81.06%	81.06%
18 Week RTT: Incomplete Pathway > 52 Weeks	**Owner - Divisional Manager Gynaecology**																	
KPI002T	Quality Schedule	Trust	=	0	Performance Value		6	3	3	1	1	1	3	5	1	0	0	0
					Trend													
					Target Value		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		305	353	334	329	387	340	359	374	230	192	196	170
					Denominator		348	397	396	401	462	411	469	453	283	290	278	243
					Performance		87.64%	88.92%	84.34%	82.04%	83.77%	82.73%	76.55%	82.56%	81.27%	66.21%	70.50%	69.96%
					Trend		▼	▲	▼	▼	▲	▼	▼	▲	▼	▼	▲	▼
					Target %		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
					Qtrly Performance		86.94%	86.94%	86.94%	82.89%	82.89%	82.89%	79.92%	79.92%	79.92%	68.80%	68.80%	68.80%
18 Week RTT: Non-Admitted Completed Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI004T	Trust Objectives	Trust	>=	95.0%	Numerator		1441	1786	1615	1681	1384	1619	1589	1605	1490	1864	1766	1417
					Denominator		1598	2021	1869	1999	1617	1924	1888	1958	1774	2230	2073	1673
					Performance		90.18%	88.37%	86.41%	84.09%	85.59%	84.15%	84.16%	81.97%	83.99%	83.59%	85.19%	84.70%
					Trend		▲	▼	▼	▼	▲	▼	▲	▼	▲	▼	▲	▼
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance		88.23%	88.23%	88.23%	84.55%	84.55%	84.55%	83.35%	83.35%	83.35%	84.45%	84.45%	84.45%
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		9.5	8.5	3.0	5.0	2.0	4.0	2.5	4	4.5	4	4.5	
					Denominator		17.5	10.5	13.5	15.5	6.0	14.0	11	8.5	12	9	11.5	
					Performance		54.29%	80.95%	22.22%	32.26%	33.33%	28.57%	22.73%	47.06%	37.50%	44.44%	39.13%	
					Trend		▼	▲	▼	▲	▲	▼	▼	▲	▼	▲	▼	
					Target %		85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
					Qtrly Performance		50.60%	50.60%	50.60%	30.99%	30.99%	30.99%	34.92%	34.92%	34.92%	41.46%	41.46%	41.46%
Cancer: 62 Day Screening Referrals (Numbers)	**Owner - Divisional Manager Gynaecology**																	
KPI033	NHSI	Gynaecology	<=	5	Performance Value		0.0	4.5	0.5	2.0	3.5	1.5	2.0	2.0	0.0	1.0	1.0	
					Trend		▼	▲	▼	▲	▲	▼	▲	▶	▼	▲	▶	
					Target Value		5	5	5	5	5	5	5	5	5	5	5	5
					Qtrly Performance Value			5	5	7	7	7	4	4	4	2	2	2
Cancer: 62 Day Screening Referrals (Percentage)	**Owner - Divisional Manager Gynaecology**																	
KPI034	NHSI	Gynaecology	>=	90.0%	Numerator		0.0	4.0	0.0	1.0	3.5	1.0	2	2	0	1	1	
					Denominator		0.0	4.5	0.5	2.0	3.5	1.5	2	2	0	1	1	
					Performance			88.89%	0.00%	50.00%	100.00%	66.67%	100.00%	100.00%		100.00%	100.00%	
					Trend			▼	▲	▲	▼	▲	▶			▶		
					Target %		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
					Qtrly Performance		80.00%	80.00%	80.00%	78.57%	78.57%	78.57%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Cancer: 104 Day Breaches	**Owner - Divisional Manager Gynaecology**																	
KPI352	Trust Objectives	Gynaecology	=	0	Performance Value		0	1	3	4	1	7	2	1	5	2	5	
					Trend		▼	▲	▲	▲	▼	▲	▼	▼	▲	▼	▲	
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value			4	4	12	12	12	8	8	8	7	7	7

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Diagnostic Tests: 6 Week Wait	**Owner - Divisional Manager Gynaecology**																	
KPI204	NHSI	Trust	>=	99.0%	Numerator		429	493	526	568	493	633	468	516	436	464	421	165
					Denominator		451	507	531	571	501	644	477	522	456	481	426	188
					Performance		95.12%	97.24%	99.06%	99.47%	98.40%	98.29%	98.11%	98.85%	95.61%	96.47%	98.83%	87.77%
					Trend		▼	▲	▲	▲	▼	▼	▼	▲	▼	▲	▲	▼
					Target %		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
					Qtrly Performance		97.25%	97.25%	97.25%	98.72%	98.72%	98.72%	97.59%	97.59%	97.59%	95.89%	95.89%	95.89%
A&E: Total Time Spent in department (95th Percentile)		**Owner - Divisional Manager Gynaecology**																
KPI012	Trust Objectives	Gynaecology	<=	240	Performance Value		236	222	221	226	213	211	221	215	210	214	218	222
					Trend		▼	▼	▼	▲	▼	▼	▲	▼	▼	▲	▲	▲
					Target Value		240	240	240	240	240	240	240	240	240	240	240	240
					Qtrly Performance Value		679	679	679	650	650	650	646	646	646	654	654	654
Complaints: Number Received		**Owner - Head of Audit, Effectiveness and Patient Experience**																
KPI038T	NHSI / Quality Strate	Trust	<=	15	Performance Value		6	6	7	3	10	4	6	4	5	7	4	3
					Trend		▼	▶	▲	▼	▲	▼	▲	▼	▲	▲	▼	▼
					Target Value		15	15	15	15	15	15	15	15	15	15	15	15
					Qtrly Performance Value		19	19	19	17	17	17	15	15	15	14	14	14

Liverpool Women's NHS Foundation Trust

	Agenda Item

MEETING	**Trust Board**
PAPER/REPORT TITLE:	Finance Performance Review Month 12 2019/20
DATE OF MEETING:	Thursday, 07 May 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	Eva Horgan, Deputy Director of Finance Janet Parker, Head of Strategic 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: Click here to enter text.	☐ ☐
FREEDOM OF INFORMATION (FOIA):	3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the Month 12 Financial Position.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Finance Performance and Business Development Committee Or type here if not on list: ***Click here to enter text.***	
	Date of meeting		Tuesday, 21 April 2020	

Executive Summary

The 2019/20 Board-approved budget was 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 12 the Trust is reporting a full year surplus of £0.3m against a breakeven plan, after adjusting for items excluded in the control total calculation. This is a slight improvement on the prior months' forecast, however the Trust does not expect to attract any additional funding support in relation to this over-performance as in previous years.

The key areas of financial performance are summarised below.[1] Note that there was an increase to planned capital spend of £1.8m as a result of an additional capital allocation from NHSI/E and internally generated funds from asset disposals. Therefore the revised Capital limit was £18m rather than the original £16.3m planned amount.

	Plan	Actual	Variance	RAG
Surplus/(Deficit) YTD	£0.0m	£0.3m	£0.3m	↑
NHS I/E Rating	3	3	0	↔
Cash	£4.6m	£4.6m	£0.0m	↑
Total CIP Achievement YTD	£3.6m	£3.6m	£0.0m	↔
Recurrent CIP Achievement YTD	£3.6m	£2.7m	-£0.9m	↓
Capital Spend YTD	£16.2m	£18.0m	£1.8m	

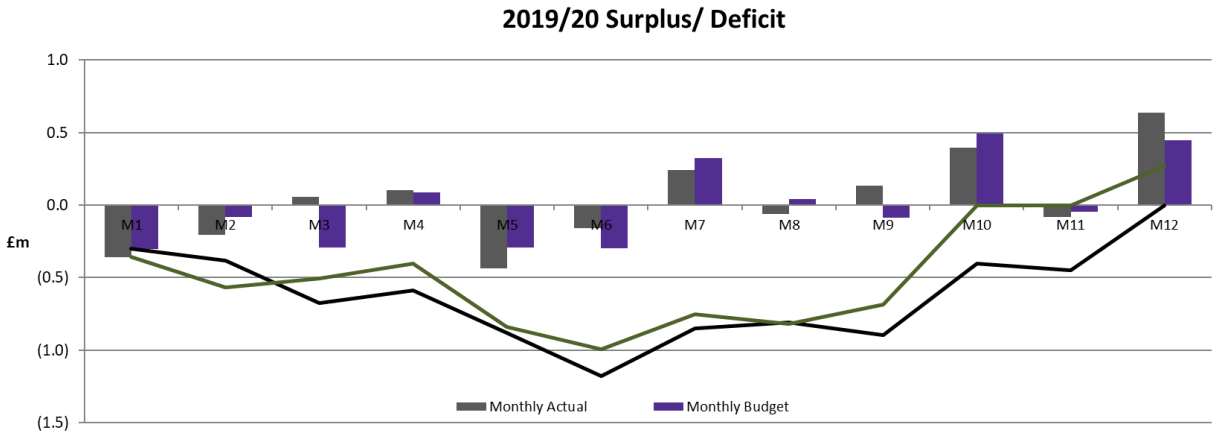
[1] NHS I/E Rating: Red is 4 or 5, Amber 3 and Green 2 or 1. Cash: Red is <£1m, Amber £1m-£4m and Green £4m+. Capital is not RAG rated. All other KPIs: Red is >10% off plan, Amber 0-10% off plan and Green at plan or better. Arrows denote movement from the prior month.

The Month 12 financial submission to NHS I/E is consistent with the contents of this report with the exception of the prescribed presentation of the increase in employer contribution rate for the NHS Pensions Scheme. Note that the final position reported is subject to audit which is now underway remotely in light of the COVID-19 pandemic.

Report

1. Summary Financial Position

At Month 12 the Trust is reporting a final year end surplus of £0.3m against a breakeven control total, after £4.6m of central funding.



This position includes a net benefit under the Acting as One arrangement of £2.3m. In addition, the position was supported by the non-recurrent release of accruals and provisions no longer required of £3.7m which was phased in over a number of months. The full CIP plan was delivered for the year, although it comprised £0.9m of non-recurrent delivery, £0.8m more than planned.

2. Divisional Summary Overview

Family Health: The divisional position remained favourable at year end (£0.6m favourable variance) with a stronger overall performance in Month 12. However, activity remained significantly behind plan in both maternity and neonates.

Gynaecology: The year-end position for the division further deteriorated to £4.5m adverse to plan. Activity across gynaecology was further impacted upon in Month 12 by the response to the COVID-19 pandemic.

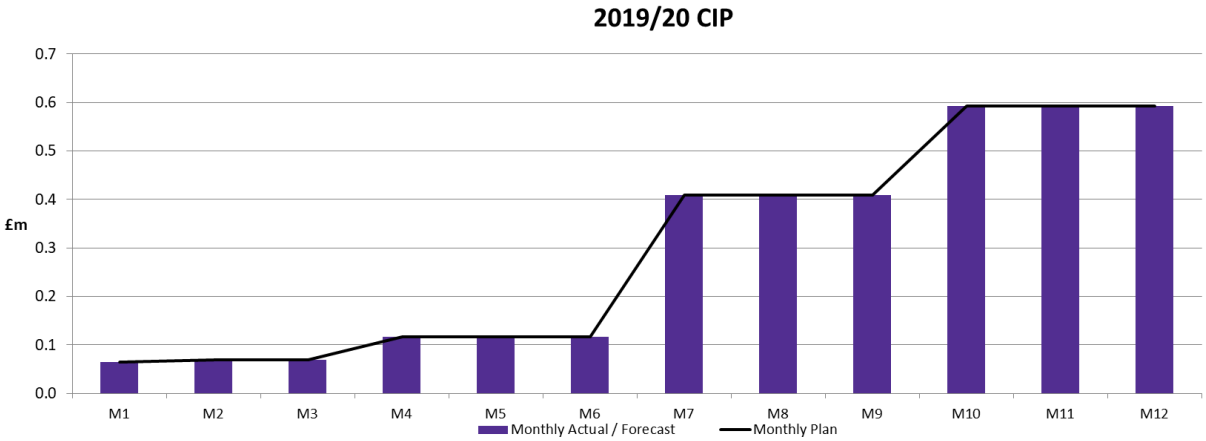
Clinical Support Services: The division remained underspent by £1.1m in line with previous months.

Agency: Agency remained within the cap level at £1.4m year to date against a cap of £1.8m.

3. CIP

The CIP target of £3.6m was delivered for the full year. While not all schemes delivered as planned, a mixture of recurrent and non-recurrent mitigation was found to cover all of this as noted in appendix one. The Trust will perform a full year post implementation review of all the 19/20 CIP schemes.

The graph below shows current performance and plan.



4. Contract Performance

Income YTD is £3.3m higher than would have been received under PbR under Acting as One, of which £1m is to be returned to the CCGs under contractual arrangements leaving a net benefit against PbR of £2.3m.

5. COVID-19 costs

£0.1m of direct revenue cost was spent in the financial year on COVID-19 which has been agreed and funded by NHS I/E. In addition, the Trust has assessed that an additional £0.3m of income was lost through sundry, private patient and PbR income under performance at the end of March 2020 of which £0.1m has also been funded directly. There is a robust system in place to identify and report the additional expense associated with the COVID-19.

6. Cash and Borrowings

The cash position improved in month to £4.6m, as expected mainly due to the receipt of a drawdown of the neonatal loan (£1.3m), PDC receipt (£1.8m), payment from the charity (£0.5m) and Quarter 3 PSF (£0.7m).

During 2019/20 the Trust was able to repay all of its outstanding Interim Revenue Support Facility of £6.7m primarily as a result of receiving the 18/19 Provider Sustainability Funding (PSF) Quarter 4, Incentive and Bonus Funding in Quarter 2 of 2019/20. The Trust also drew down a further £11.0m of the agreed £15.0m Neonatal capital build funding. The £15m capital loan to complete the build forms part of the government's recent announcement to write off £13bn of historic debt. It is expected that this will convert to PDC in September 2021. The year-end treatment and disclosure in relation to this is currently being finalised.

7. Capital Expenditure

Capital expenditure increased in month following the re-prioritisation exercise, which ensured that essential capital spend such as beds and the Trust's IT network were brought forward given the availability of Capital in 2019/20 and partly in response to COVID-19.

Capital expenditure in month was £3.5m and the total capital expenditure for the year was £18m against a revision to planned delegated limits (CDEL) of £18m given the additional capital allocation and internally generated funds from asset disposals.

There was a concerted and well managed effort across procurement, the clinical divisions and finance to manage the capital expenditure and ensure orders were placed and received by 31 March 2020 to utilise all of the capital funding available and spend up to the capital allocation.

Further Detail is contained in Appendix One.

8. Balance Sheet

The Aged Debtors balance reduced in month by £1.2m (to £5.5m), as a result of a continued strong focus on debt recovery.

9. BAF Risk

The financial year is concluded and no further changes are required to the in-year BAF risk for 2019/20 which reached the target score of 10. The risk for 2020/21 is under review and will be presented at Month 1.

10. Outlook

There is significant uncertainty in relation to the impact of the COVID-19 outbreak on the financial position of the Trust in 20/21. The operational planning round has been paused and the Trust is following the national guidelines for income payment for Months 1 – 4. A Month 1 financial return however will be submitted to NHSI/E and reported to Board. The Trust remains committed to maintain strong financial governance during this phase.

11. Conclusion & Recommendation

The Board are asked to note the Month 12 financial position.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M12

YEAR ENDING 31 MARCH 2020

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M12
YEAR ENDING 31 MARCH 2020

USE OF RESOURCES RISK RATING	YEAR TO DATE Budget	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)		
(a) EBITDA + Interest Receivable	6,661	6,928
(b) PDC + Interest Payable + Loans Repaid	7,262	9,328
CSC Ratio = (a) / (b)	**0.92**	**0.74**
NHSI CSC SCORE	**4**	**4**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25		
LIQUIDITY		
(a) Cash for Liquidity Purposes	(13,172)	(26,419)
(b) Expenditure	110,554	106,444
(c) Daily Expenditure	302	291
Liquidity Ratio = (a) / (c)	**(43.6)**	**(90.8)**
NHSI LIQUIDITY SCORE	**4**	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)		
I&E MARGIN		
Deficit (Adjusted for donations and asset disposals)	(4)	(139)
Total Income	(117,167)	(113,147)
I&E Margin	**0.0%**	**0.1%**
NHSI I&E MARGIN SCORE	**3**	**2**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)		
I&E MARGIN VARIANCE FROM PLAN		
I&E Margin (Actual)		0.10%
I&E Margin (Plan)		0.00%
I&E Variance Margin	**0.00%**	**0.10%**
NHSI I&E MARGIN VARIANCE SCORE	**1**	**1**
Ratio Score 1 = 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%		

year to date budget. This is because NHSI recognise the fact that an organisation would not "plan" to have a variance from plan and have not applied a calculated ratio to the budgeted columns of this metric.

AGENCY SPEND		
YTD Providers Cap	1,788	1,788
YTD Agency Expenditure	1,188	1,444
	-34%	**-19%**
NHSI AGENCY SPEND SCORE	**1**	**1**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%		
Overall Use of Resources Risk Rating	**3**	**3**

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

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M12
YEAR ENDING 31 MARCH 2020

INCOME & EXPENDITURE	MONTH			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance
Income						
Clinical Income	(8,821)	(7,450)	(1,370)	(104,520)	(100,694)	(3,826)
Non-Clinical Income	(1,321)	(1,342)	20	(12,647)	(12,619)	(28)
Total Income	**(10,142)**	**(8,792)**	**(1,350)**	**(117,167)**	**(113,312)**	**(3,854)**
Expenditure						
Pay Costs	5,940	5,616	324	70,856	69,950	906
Non-Pay Costs	2,187	935	1,253	26,634	23,482	3,152
CNST	1,009	1,000	8	13,064	13,013	51
Total Expenditure	**9,136**	**7,551**	**1,585**	**110,554**	**106,445**	**4,109**
EBITDA	**(1,006)**	**(1,241)**	**235**	**(6,613)**	**(6,868)**	**255**
Technical Items						
Depreciation	392	395	(3)	4,641	4,606	35
Interest Payable	33	36	(3)	402	328	74
Interest Receivable	(1)	(4)	3	(48)	(60)	12
PDC Dividend	135	145	(10)	1,617	1,738	(121)
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	(17)	17
Total Technical Items	**558**	**571**	**(13)**	**6,613**	**6,596**	**17**
(Surplus) / Deficit	**(448)**	**(670)**	**222**	**0**	**(272)**	**272**
NHSI Adjustments Re: Control Total Perfomance:						
18/19 Additional PSF		*0*	*0*		*165*	*(165)*
Add back all I&E impairments/(reversals)		*(304)*	*304*		*(304)*	*304*
Remove capital donations/grants I&E impact		*89*	*(89)*	*-4*	*83*	*(87)*
Remove annual leave accrual impact due to Covid-19		*(25)*	*25*		*(25)*	*25*
Profit on disposal of equipment		*0*	*0*		*25*	*(25)*
Variance against Control Total for the purposes of PSF and FRF	***(448)***	***(910)***	***462***	***(4)***	***(328)***	***324***

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M12
YEAR ENDING 31 MARCH 2020

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs						
Board, Execs & Senior Managers	379	451	(73)	4,558	3,858	700
Medical	1,520	1,269	251	17,682	17,566	116
Nursing & Midwifery	2,598	2,657	(59)	30,719	31,247	(527)
Healthcare Assistants	452	423	28	5,393	4,997	396
Other Clinical	349	333	16	4,842	4,524	319
Admin Support	183	172	11	2,140	1,969	171
Corporate Services	360	402	(42)	4,340	4,346	(6)
Agency & Locum	98	(92)	190	1,180	1,444	(263)
Total Pay Costs	**5,940**	**5,616**	**324**	**70,856**	**69,950**	**906**
Non Pay Costs						
Clinical Suppplies	635	644	(9)	7,860	8,305	(445)
Non-Clinical Supplies	513	632	(119)	6,116	5,963	154
CNST	1,009	1,000	8	13,064	13,013	51
Premises & IT Costs	526	774	(248)	5,931	6,647	(716)
Service Contracts	513	(1,116)	1,628	6,726	2,567	4,160
Total Non-Pay Costs	**3,196**	**1,935**	**1,261**	**39,698**	**36,495**	**3,203**
Total Expenditure	**9,136**	**7,551**	**1,585**	**110,554**	**106,445**	**4,109**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
BUDGET ANALYSIS: M12
YEAR ENDING 31 MARCH 2020

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR Budget	YEAR Actual	YEAR Variance
Maternity						
Income	(3,805)	(3,741)	(64)	(44,885)	(44,785)	(99)
Expenditure	1,864	1,622	242	22,204	22,082	122
Total Maternity	**(1,941)**	**(2,119)**	**178**	**(22,681)**	**(22,704)**	**23**
Neonatal						
Income	(1,444)	(1,605)	161	(17,072)	(17,423)	351
Expenditure	1,100	1,077	22	13,158	12,894	264
Total Neonatal	**(344)**	**(527)**	**183**	**(3,914)**	**(4,529)**	**615**
Division of Family Health - Total	**(2,285)**	**(2,646)**	**361**	**(26,595)**	**(27,232)**	**638**
Gynaecology						
Income	(2,468)	(2,263)	(204)	(27,724)	(25,745)	(1,980)
Expenditure	1,000	1,045	(44)	11,445	12,232	(787)
Total Gynaecology	**(1,467)**	**(1,219)**	**(249)**	**(16,280)**	**(13,512)**	**(2,767)**
Hewitt Centre						
Income	(971)	(450)	(522)	(11,001)	(10,053)	(948)
Expenditure	667	862	(195)	8,130	8,865	(735)
Total Hewitt Centre	**(304)**	**413**	**(717)**	**(2,871)**	**(1,188)**	**(1,684)**
Division of Gynaecology - Total	**(1,771)**	**(806)**	**(965)**	**(19,151)**	**(14,700)**	**(4,451)**
Theatres						
Income	(39)	(39)	(0)	(472)	(484)	11
Expenditure	702	520	181	8,411	8,218	192
Total Theatres	**662**	**481**	**181**	**7,938**	**7,735**	**204**
Genetics						
Income	(322)	(187)	(134)	(4,640)	(4,727)	87
Expenditure	188	138	50	2,979	3,045	(66)
Total Genetics	**(133)**	**(49)**	**(85)**	**(1,661)**	**(1,682)**	**21**
Other Clinical Support						
Income	(31)	(21)	(10)	(357)	(316)	(40)
Expenditure	682	455	228	8,121	7,158	963
Total Clinical Support	**651**	**434**	**217**	**7,764**	**6,842**	**922**
Division of Clinical Support - Total	**1,181**	**866**	**314**	**14,041**	**12,894**	**1,147**
Corporate & Trust Technical Items						
Income	(1,062)	(487)	(576)	(11,015)	(9,780)	(1,235)
Expenditure	3,490	2,403	1,087	42,719	38,546	4,174
Total Corporate	**2,428**	**1,916**	**512**	**31,705**	**28,766**	**2,938**
(Surplus) / Deficit	**(448)**	**(670)**	**222**	**0**	**(272)**	**272**

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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CIP: M12
YEAR ENDING 31 MARCH 2020

				MONTH 12			YEAR		
NHSI SCHEME REFERENCE	SCHEME NAME	ACCOUNTING	RISK RATING	TARGET	ACTUAL	VARIANCE	TARGET	Actual	VARIANCE
Trust scheme 1	Car Parking Consumables	Non-Pay	Medium	1	1	0	12	12	0
Trust scheme 2	CNST Maternity Incentive	Non-Pay	Medium	160	168	0	960	1,011	51
Trust scheme 3	Estates Income Generation	Income	Low	3	1	(2)	36	24	(12)
Trust scheme 4	Contract Savings	Pay	Low	14	14	0	168	168	0
Trust scheme 5	Coding & Counting	Income	Low	13	13	0	156	156	0
Trust scheme 6	Decontamination Contract	Non-Pay	Low	3	3	0	36	36	0
Trust scheme 7	Meeting Utilisation	Income	Low	1	1	0	11	10	(1)
Trust scheme 8/9	HFEA Tender	Income/Pay	Medium	2	2	0	24	24	0
Trust scheme 10	HTE Contract Fees	Non-Pay	Low	3	3	0	36	113	77
Trust scheme 11	Imaging Income Opportunities	Income	Low	2	2	0	24	24	0
Trust scheme 12	Midwifery Productivity	Pay	Medium	23	23	0	228	228	0
Trust scheme 13	Pharmacy Review	Non-Pay	Medium	31	72	(17)	279	179	(100)
Trust scheme 14	Private Patient Fees	Income	Low	33	0	0	198	212	14
Trust scheme 15	Procurement (various)	Non-Pay	Medium	95	4	(95)	570	17	(553)
Trust scheme 16	Rateable Value Review	Non-Pay	Medium	5	0	(5)	30	0	(30)
Trust scheme 17	CQC Fees	Non-Pay	Low	7	7	0	84	84	0
Trust scheme 18	Restructuring	Pay	Low	7	7	0	84	84	0
Trust scheme 19	Section 106	Income	High	167	0	(167)	501	0	(501)
Trust scheme 20	Job Planning	Pay	Medium	4	4	0	44	44	0
Trust scheme 21	Sperm Bank	Non-Pay	High	17	0	(17)	51	0	(51)
Trust scheme 22	Sutures	Non-Pay	Low	2	2	0	24	24	0
Non-recurrent Mitigation	Gynaecology	Non-Pay	Low	0	0	0	0	1	1
Recurrent Mitigation	Genetics Overheads	Income	Low	0	46	46	0	137	137
Recurrent Mitigation	Contracts Review	Non-Pay	Low	0	0	98	0	209	209
Non-recurrent Mitigation	Family Health	Non-Pay	Low	0	0	0	0	123	123
Non-recurrent Mitigation	Corporate	Non-Pay	Low	0	221	159	0	636	636
TOTAL				**593**	**593**	**0**	**3,556**	**3,556**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BALANCE SHEET: M12
YEAR ENDING 31 MARCH 2020

BALANCE SHEET £'000	YEAR TO DATE Opening	YEAR TO DATE M12 Actual	YEAR TO DATE Movement	YEAR TO DATE Budget	YEAR TO DATE M12 Actual	YEAR TO DATE Movement
Non Current Assets	**79,968**	**92,283**	12,315	**91,862**	**92,283**	421
Current Assets						
Cash	9,066	4,647	(4,419)	4,600	4,647	47
Debtors	7,273	3,922	(3,351)	6,656	3,922	(2,734)
Inventories	489	432	(57)	452	432	(20)
Total Current Assets	**16,828**	**9,001**	**(7,827)**	**11,708**	**9,001**	**(2,707)**
Liabilities						
Creditors due < 1 year - Capital Payables	(1,347)	(2,809)	(1,462)	(266)	(2,809)	(2,543)
Creditors due < 1 year - Trade Payables	(13,661)	(12,947)	714	(15,775)	(12,947)	2,828
Creditors due < 1 year - Deferred Income	(2,428)	(2,918)	(490)	(3,471)	(2,918)	553
Creditors due > 1 year - Deferred Income	(1,654)	(1,623)	31	(1,618)	(1,623)	(5)
Loans	(13,635)	(17,320)	(3,685)	(18,802)	(17,320)	1,482
Provisions	(4,631)	(1,697)	2,934	(4,870)	(1,697)	3,173
Total Liabilities	**(37,356)**	**(39,314)**	**(1,958)**	**(44,802)**	**(39,314)**	**5,488**
TOTAL ASSETS EMPLOYED	**59,440**	**61,970**	**2,530**	**58,768**	**61,970**	**3,202**
Taxpayers Equity						
PDC	40,088	42,519	2,431	41,313	42,519	1,206
Revaluation Reserve	14,503	14,330	(173)	15,367	14,330	(1,037)
Retained Earnings	4,849	5,121	272	2,088	5,121	3,033
TOTAL TAXPAYERS EQUITY	**59,440**	**61,970**	**2,530**	**58,768**	**61,970**	**3,202**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
CASHFLOW STATEMENT: M12
YEAR ENDING 31 MARCH 2020

CASHFLOW STATEMENT	YEAR TO DATE		
£'000	Budget	Actual	Variance
Cash flows from operating activities	1,971	2,310	(339)
Depreciation and amortisation	4,641	4,606	35
Impairments and reversals	0	304	(304)
Income recognised in respect of capital donations (cash and non-cash)	0	(89)	89
Movement in working capital	(118)	795	(913)
Net cash generated from / (used in) operations	**6,494**	**7,926**	**(1,432)**
Interest received	52	60	(8)
Purchase of property, plant and equipment and intangible assets	(16,249)	(16,557)	308
Proceeds from sales of property, plant and equipment and intangible assets	721	42	679
Net cash generated from/(used in) investing activities	**(15,476)**	**(16,455)**	**979**
PDC Capital Programme Funding - received	1,225	2,431	(1,206)
Loans from Department of Health Capital - received	10,410	10,947	(537)
Loans from Department of Health Capital - repaid	(612)	(612)	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	(200)	(308)	108
PDC dividend (paid)/refunded	(1,611)	(1,698)	87
Net cash generated from/(used in) financing activities	**4,582**	**4,110**	**472**
Increase/(decrease) in cash and cash equivalents	**(4,400)**	**(4,419)**	**19**
Cash and cash equivalents at start of period	9,000	9,066	(66)
Cash and cash equivalents at end of period	**4,600**	**4,647**	**(47)**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding at M12
Loans from Department of Health - Capital (ITFF) - 2.0% Interest Rate	5,500	(2,752)	2,748
Loans from Department of Health - Capital (Neonatal) - 2.54% Interest Rate	14,572	0	14,572
Loans from Department of Health - Revenue - 1.50% Interest Rate	14,612	(14,612)	0
Total	**34,684**	**(17,364)**	**17,320**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M12
YEAR ENDING 31 MARCH 2020

CAPITAL EXPENDITURE	Year to Date		
£'000	Budget	Actual	Variance
Neonatal New Build	9,635	10,264	-629
Non NICU - Site Wide Infrastructure	775	912	-137
Addition - Car Parking		109	-109
Addition- CCTV		95	-95
Addition - Other build		74	-74
Build Project Total	**10,410**	**11,453**	**-1,043**
Fire Safety (general)	100	100	0
Fire Door Replacement Programme	80	92	-12
Emergency Lighting	150	171	-21
Site Wide Infrastructure	50	0	50
Addition - C-Cure upgrade	0	42	-42
Other Estates Total	**380**	**406**	**-26**
Data Warehouse	12	12	0
EDMS	150	36	114
Maternity EPR	200	87	113
GDE Fast Follower	2,348	2,973	-625
Addition - Networking and WiFi		394	-394
IM&T Total	**2,710**	**3,502**	**-792**
Neonatal Equipment	861	838	23
Maternity	50	92	-42
Imaging	310	269	41
Gynae & Surgical Services	720	717	3
Genetic Labs	120	0	120
Embryology	116	118	-2
Addition - Ultrasounds Scanners		165	-165
Addition - Ambulatory Equipment		145	-145
Addition - Retcam (Neonates)		82	-82
Addition - Maternity Beds		191	-191
Addition - Teaching Aids	0	9	-9
Medical Equipment Total	**2,177**	**2,627**	**-450**
Other	569	0	569
Covid-19	0	31	-31
Additional PDC re GDE Fast Follower	1,800		1,800
Grand Total	**18,046**	**18,020**	**26**

Liverpool Women's NHS Foundation Trust

	Agenda Item
MEETING	**Trust Board Meeting**
PAPER/REPORT TITLE:	**Board Assurance Framework**
DATE OF MEETING:	Thursday, 07 May 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Mark Grimshaw, 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	April 2020

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 2020/21 (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.

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 to a number of risks. In relation to two of the risks, updates have been completed which include significant review and an update reducing the current score:

- 2297 - Condition: Location, size, layout and accessibility of current services do not provide for sustainable integrated care or safe and high-quality service provision.

- 2293 - Condition: Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust.

Since the last report to the Board, there is the proposal to add the following risk to the BAF:

- 2340 - Condition: Failure to maintain current levels of service, manage increased demands and provide support to the wider system. Failure to recover to pre-Covid-19 service levels following the pandemic. Current risk score 4x4=16 with target score of 8. Assurance committee is FPBD

The report reflects the process of the active 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.

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: April 2020

Please refer to appendix 1

2. Sub-Committee Changes to Risks

Since the last report to the Board, the sub-committees have further reviewed the risks within their remit and there have been some minor changes or alterations completed to a number of risks. In relation to two of the risks, the current risk score has been reduced:

- 2297 - Condition: Location, size, layout and accessibility of current services do not provide for sustainable integrated care or safe and high-quality service provision.
  Risk reviewed by Head of Strategy and Transformation. Target completion dates for a number of actions amended in light of Trust response to Covid-19. Progress against all actions noted. One action completed (develop counterfactual argument) and new action added; external review of counterfactual case.

- 2293 - Condition: Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust. Following discussion at PPF and given the consistent improvement in the engagement score since 2016, risk score revised.

3. New Risks and Closed Risk

Since the last report to the Trust Board, it is proposed to add the following risk to the BAF. This has been considered by the Board's sub-committees during April 2020

- 2340 - Condition: Failure to maintain current levels of service, manage increased demands and provide support to the wider system. Failure to recover to pre-Covid-19 service levels following the pandemic. Current risk score 4x4=16 with target score of 8. Assurance committee is FPBD

4. Conclusions

The report reflects the active 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.

5. Recommendation

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 April 2020

Risk No.	Assurance Committee	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	Finance, Performance and Business Development Committee	**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	3	15	10	⟺	Y	Y	Y	Reviewed at March FPBD, no changes proposed. Risk is at target score.
1986	Finance, Performance and Business Development Committee	**Condition:** The Trust is not financially sustainable beyond the current financial year **Cause:** On-going 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	Reviewed at FPBD March 2020, no changes required.
2266	Quality Committee	**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	Work is on-going but has been reduced due to resources required to assist with Covid19 situation.
2293	Putting People First Committee	**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.	4	2	8	6	⇩	Y	Y	Y	Recommendation to reduce risk score to 8 has been put forward to PPF committee on 20/4/20. Following discussion at PPF and Given the consistent improvement in the engagement score since 2016, risk score revised.

Risk No.	Assurance Committee	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	Putting People First Committee	**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	3	15	10	⟺	Y	Y	Y	No change to risk - actions on-going.
2295	Quality Committee	**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	Work is on-going in relation to this risk by the governance team. The roll out of the CQC module to enable on-going and quarterly reviews of KLOE compliance has been delayed due to the current situation management of Covid 19.
2297	Quality Committee	**Condition:** Location , size, layout and 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 co-located paediatric surgical support. **Consequence:** Patient harm, poor continuity of care, poor patient experience due to transfer away for booking location.	5	5	25	25	⟺	Y	Y	Y	Risk reviewed by Head of Strategy and Transformation. Target completion dates for a number of actions amended in light of Trust response to COVID19. Progress against all actions noted. One action completed (develop counterfactual argument) and new action added; external review of counterfactual case.
2337	Quality Committee	**Condition**: The Trusts current clinical records system (paper and Electronic) are sub-optimal. **Cause:** Failure to upgrade present Electronic Patient Records system in recent years and failure of 3 Trust electronic Patient Records to deliver on time. **Consequence:** There is potential impact on patient safety, quality, experience and negative effect on staff, Staff are unable to work effectively and safely. Reporting requirements will be impacted if systems fail. There is a financial cost of replacement and penalties to the Trust, of withdrawal from three way electronic Patient record	5	4	20	20	⟺	Y	Y	Y	No changes in current risk - actions on-going.

Risk No.	Assurance Committee	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	
2335	Finance, Performance and Business Development Committee	**Condition:** Major and sustained failure of essential IT systems due to a cyber attack **Cause**: ineffective cyber controls and technology, inadequate investment in systems and infrastructure, failure in skills or capacity of staff or service providers, poor end user culture regarding cyber security and IT systems use, inadequate contract management. **Consequence**: Reduced quality or safety of services, financial penalties, reduced patient experience, loss of reputation, loss of market share/ commissioner contracts.	5	3	15	10	⟷	Y	Y	Y	Risk reviewed by CIO no material change to risk.
2340	Finance, Performance and Business Development Committee	**Condition:** Failure to maintain current levels of service, manage increased demands and provide support to the wider system. Failure to recover to pre-Covid-19 service levels following the pandemic. **Cause:** Increased demand on services and the requirement to provide support to the wider system for ITU and acute bed capacity during the Covid-19 pandemic. Cancellation of a number of elective services to release beds to the wider system. There are a high number of clinical staff not able to work due to Covid-19 health restrictions. Requirement to follow national guidelines **Consequence:** Lack of service provision to LWH patient groups, reduced services in some areas, life altering impact on some patients, reduced patient experience, impact on patient safety and potential loss of reputation and inability to recover service provision in the future.	4	4	16	8	New Risk	Y	Y	Y	Following discussion at the Trust Board, Board committees and executive meetings including the Operations and Oversight meeting for Covid-19, a new BAF risk has been developed and added to the BAF by Head of Governance and Quality.

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Financial Services | **Service / Department:** Finance | **Position at:** 30/04/2020 18:41:40

Risk Number: 1986 **Version:** 6 **Domain:** Finance Including Claims **Linked Risks:**

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

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

Risk Appetite: 3.Moderate

Assurance Committee: Finance, Performance & **Review Due:** 28/05/2020

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; reduction in activity and income; declining birth rates.

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

Last Review Narrative: **Date:** 28/04/2020 **Reviewed By:** Eva Horgan

Updated re Covid-19

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. Application for emergency capital for mitigations on site	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. Financial short term impact of mitigation's on site	Not Yet Tested	5 Year plan approved (BoD Nov 2014) 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) SOC for preferred option approved by Board - Sept 17 Submission of Cheshire and Mersey STP capital bid Summer 2018 ranked no1 of schemes Long Term Plan Submission Nov 19 NHSE/I use of resources rating above 3 over 5 year period 5 year Strategy refresh underway	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 Capital to invest on site while awaiting approval	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
4	Business Case 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.	02/05/2022	29/07/2022	Eva Horgan	Work ongoing Date Entered : 09/08/2019 14:11 Entered By : Christopher Lube	Ongoing	/ /
6	Business Case 2 - Public consultation by CCG following development of preferred option (Subject to capital bid)	01/07/2021	29/10/2021	Eva Horgan	Dependent on external influences and agencies Date Entered : 09/08/2019 14:14 Entered By : Christopher Lube	Ongoing	/ /
7	Business Case 3 - Decision making business case produced in partnership with CCG and final decision following outcome of public consultation required	01/11/2021	29/04/2022	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	31/07/2020	Eva Horgan	Put back due to Covid-19 pandemic. Date Entered : 28/04/2020 14:05 Entered By : Eva Horgan ---------- Timescale TBC - requirements to be confirmed, subject to outcome of bid. Date Entered : 09/08/2019 14:18	Ongoing	/ /

					Entered By : Christopher Lube		
11	Merger 1 - Agree in principle to proceed to merger	13/02/2020	31/07/2020	Eva Horgan	Put back due to Covid-19 pandemic Date Entered : 28/04/2020 14:05 Entered By : Eva Horgan	Ongoing	/ /
12	Merger 2 - Establish Merger Project (internal group)	01/04/2020	30/06/2020	Eva Horgan		Ongoing	/ /
13	Merger 3 - Develop Strategic case working with external organisations	01/07/2020	31/03/2021	Eva Horgan		Ongoing	/ /
14	Merger 4 - Develop and complete business case in conjunction with external organisations	01/04/2021	30/11/2021	Eva Horgan		Ongoing	/ /
15	Merger 5 - Merger / acquisition approval process with external organisation	01/12/2021	31/03/2022	Eva Horgan		Ongoing	/ /
16	Shared Exec Model 1 - Develop Shared Exec Model - Work in partnership with external body (LUHFT) in order to develop and assess options for a shared executive model which will deliver financial savings	01/07/2020	31/03/2021	Eva Horgan		Ongoing	/ /
17	Shared Exec Model 2 - Agree Model - Review and agree preferred model in conjunction with external organisation (LUHFT)	01/04/2021	30/06/2021	Eva Horgan		Ongoing	/ /
18	Shared Exec Model 3 - Implement Shared Exec Model - Detailed implementation plan to be developed in conjunction with external organisation (LUHFT) to implement agreed shared exec model.	01/10/2021	31/12/2021	Eva Horgan		Ongoing	/ /
19	Procurement 1 - OJEU - Undertake most appropriate formal procurement process to appoint primary building contractor & architect	03/10/2022	30/12/2022	Eva Horgan		Ongoing	/ /
20	Procurement 2 - PQQ Stage - Procurement team to complete Pre Qualification Questionnaire stage	02/01/2023	31/03/2023	Eva Horgan		Ongoing	/ /
21	Procurement 3 - ITPD Stage - Procurement team to complete Invitation to Participate in Dialogue stage	03/04/2023	31/10/2023	Eva Horgan		Ongoing	/ /
22	Procurement 4 - Financial Close - Procurement team to complete financial close stage	01/08/2023	31/01/2024	Eva Horgan		Ongoing	/ /
23	Procurement 5 - Contract Award - Trust to approve contract award	01/02/2024	29/03/2024	Eva Horgan		Ongoing	/ /
24	Short term investment through operational plan to ensure safety on site	06/01/2020	31/07/2020	Eva Horgan	On hold due to Covid-19 pandemic. Date Entered : 28/04/2020 14:04 Entered By : Eva Horgan	Ongoing	/ /
25	Emergency capital funding application - submit emergency capital funding application to NHSI/E regarding new build and refurbishment work to house mitigations designed to reduce clinical risk on isolated site	06/01/2020	31/07/2020	Jennifer Huyton	Capital bid submitted to NHSI, was due for review in April. Covid-19 pandemic means this is on hold at least until the summer. There is a lack of clarity on the national capital allocation process. Likely to be managed by STP but no detail available as of April 2020. To be further reviewed once detail about the regime is available. Date Entered : 28/04/2020 14:03 Entered By : Eva Horgan	Ongoing	/ /
26	Business Case 1 - Work in partnership with CCG to refresh PCBC document, including stakeholder engagement and refresh of data	01/01/2020	31/12/2020	Jennifer Huyton		Ongoing	/ /
27	Business Case 5 - Approval for funding from NHSI/E based on refreshed SOC	01/08/2022	31/10/2022	Eva Horgan		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:** Governance **Service / Department:** Governance **Position at:** 30/04/2020 18:41:40

Risk Number: 2266 **Version:** 2 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

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

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 04/05/2020

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:** 04/04/2020 **Reviewed By:** Christopher Lube

Work is ongoing but has been reduced due to resources required to assist with Covid19 situation.

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	Jeanette Chalk	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	/ /
3	Develop better reporting from the Ulysses System	01/04/2019	30/04/2020	Christopher Lube	Upgrades commencing to be rolled out to staff, review and close march 2020. Date Entered : 04/03/2020 13:23 Entered By : Christopher Lube ---------- Updates to the Ulysses system have been completed and a plan is in place to roll out by 1st Feb 2020. Some final testing to be completed and training. Date Entered : 11/01/2020 10:40 Entered By : Christopher Lube ---------- The Upgrade of the Ulysses system is progressing. A slight delay was encountered due to the	Ongoing	/ /

					need to move to a new server. 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. Date Entered : 31/07/2019 10:56 Entered By : Christopher Lube		
6	Business case for the provision of Human Factors Training to be developed and submitted to education governance committee	01/04/2019	04/05/2020	Linda Watkins	Business case for sim lead developed. Need to identify funding. As a result of feedback need to develop simulation strategy for the trust to present to ed gov. Delay as DME has been supporting colleague on mat leave as well as the acting specialty tutor for O&G after Specialty tutor resigned. Date Entered : 29/01/2020 17:57 Entered By : Linda Watkins ---------- Discussions are ongoing via Ed Gov Committee Date Entered : 11/01/2020 10:44 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 information Date Entered : 31/07/2019 11:01 Entered By : Christopher Lube	Ongoing	/ /
7	New risk management and patient safety training package to be developed	01/04/2019	01/06/2020	Christopher Lube	Work on this development has been delayed due to need to deal with Covid19 situation.	Ongoing	/ /

Date Entered : 04/04/2020 13:42
Entered By : Christopher Lube

Work on Risk Training Package is ongoing with the appointment of new Risk and Patient Safety Manager. RCA training dates are available for staff to book on, bespoke training continues to be available and Risk Management is part of Cooperate induction and Annual Mandatory Training,

Date Entered : 11/01/2020 10:48
Entered By : 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

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:** 30/04/2020 18:41:40

Risk Number: 2293 **Version:** 4 **Domain:** HR/Organisational Development/ **Linked Risks:**

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

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

Risk Appetite: 3.Moderate

Assurance Committee: Putting People First **Review Due:** 30/05/2020

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.

Last Review Narrative: **Date:** 15/04/2020 **Reviewed By:** Rachel London

Recommendation to reduce risk score to 8 has been put forward to PPF committee on 20/4/20.

Following discussion at PPF and Given the consistent improvement in the engagement score since 2016, it is proposed that the risk score is revised.

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 PDR training programme in place	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	Aspirant managers programme in place	01/04/2019	31/03/2020	Jeanette Chalk	Aspirant managers programme in place and 1st cohort have completed with 2nd cohort to commence. Date Entered : 16/11/2019 12:04 Entered By : Christopher Lube --- 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	Ongoing	/ /

4	Launch of Fair and Just Culture Project	01/04/2019	31/03/2020	Chris McGhee	Date Entered : 08/08/2019 11:35 Entered By : Christopher Lube Year 1 completed on timescale in accordance with project plan. Date Entered : 16/11/2019 12:04 Entered By : Christopher Lube ---------- Initial development work and staff training in progress Date Entered : 09/08/2019 15:24 Entered By : Christopher Lube		Ongoing	/ /

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

Current Assessment		
Severity	**Likelihood**	**Risk Score**
4 Major	2 Unlikely	8

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:** 30/04/2020 18:41:40

Risk Number: 2294 **Version:** 7 **Domain:** HR/Organisational Development/ **Linked Risks:**

Executive Lead: Michelle Turner **Operational Lead:** Rachel London

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

Risk Appetite: 3.Moderate

Assurance Committee: Putting People First **Review Due:** 14/05/2020

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.

Last Review Narrative: **Date:** 14/04/2020 **Reviewed By:** Rachel London

Actions reviewed and progress against actions recorded

Currently no change to risk proposed, workforce availability is under short term pressure due to Covid-19 and this will be reviewed on a regular basis but at the current time does not impact on the longer term, strategic risk.

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 Shared appointments with other providers Secured operating time at the LUH Increased consultant recruitment with incentives Neonatal Partnership Maternity introduction of ACP Midwives Policy to mitigate impact on LTA and AA on senior staff in place	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
4	Await outcome of Business case sent to NHSI to develop E-Rostering System Collaborative	16/11/2019	31/03/2020	Jeanette Chalk	The Trust was unsuccessful in bidding for national funds to purchase the Allocate doctors rostering system. This system would not address the shortage in certain specialties but would be a more efficient means to roster the medical workforce. A business case will be developed to purchase the system ourselves, this has been delayed due to Covid-19 issues and will be developed by Autumn 2020. Date Entered : 14/04/2020 14:51	Ongoing	/ /

5	Medical Workforce Recruitment and Retention process being developed	01/11/2019	31/03/2020	Jeanette Chalk	Entered By : Rachel London There are a number of workstreams around identifying and developing talent in the medical workforce at junior doctor level and developing pathways to consultant level. A bespoke leadership programme for consultants has also been developed to deliver a pipeline of talent for future clinical director roles. These plans need to be co-ordinated into an overall medical recruitment and retention plan. This has been delayed due to Covid-19 and will be developed by the summer. Date Entered : 14/04/2020 14:54 Entered By : Rachel London		Ongoing	/ /

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

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	3 Possible	15

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:** 30/04/2020 18:41:41

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

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

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 04/05/2020

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.

Last Review Narrative: **Date:** 04/04/2020 **Reviewed By:** Christopher Lube

Work is ongoing in relation to this risk by the governance team. The roll out of the CQC module to enable ongoing and quarterly reviews of KLOE compliance has been delayed due to the current situation management of Covid 19.

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 QC in relation to risk with appropriate information	01/04/2019	31/08/2020	Christopher Lube	New CQC compliance module roll out has been delayed due to Covid19 situation. As soon as able this will be commenced. Date Entered : 04/04/2020 13:39 Entered By : 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	31/07/2020	Janet Brennan	Due to the current Covid19 situation the roll out of ward accreditation has been delayed. Date Entered : 04/04/2020 13:31 Entered By : Christopher Lube ---------- Meeting with Ward Accreditation providers due on 08/08/19. Progress on pilot to be discussed	Ongoing	/ /

					and review of software to log data. Date Entered : 08/08/2019 15:00 Entered By : Christopher Lube		
3	To embed process for monitoring of regulatory reports and action plans at divisional boards	01/04/2019	31/03/2020	Christopher Lube	Reports and action plans from regulatory inspection are now actioned, reviewed and monitored at Divisional Board level and assurance on progress provided up to Trust groups and committees as required Action completed Date Entered : 04/04/2020 13:34 Entered By : 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	Completed	04/04/2020
4	Report regulatory exceptions form Divisional Boards to Quality Committee	01/04/2019	31/03/2020	Christopher Lube	Exception reporting process from Divisional Board to Trust Groups and Sub committee in place. Reports into Quality committee via direct reports or via senate chairs reports. Date Entered : 04/04/2020 13:36 Entered By : 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	Completed	04/04/2020
5	Undertake intermittent deep dive reviews into specialist services	01/04/2019	31/03/2021	Christopher Lube	This is a long term ongoing action which will be completed as and when a deep dive is required. Action put onto annual review basis Date Entered : 04/04/2020 13:38 Entered By : 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	/ /
6	New CQC monitoring system via Ulysses to be introduced	01/07/2019	31/07/2020	Christopher Lube	New module due to roll out but	Ongoing	/ /

across all core areas of the Trust. Process will provide quarterly reports to Quality Committee on CQC commence levels and associated actions.

has been delayed slightly due to COovid19 situation.

Date Entered : 04/04/2020 13:29
Entered By : Christopher Lube

New module has been commissioned and developed by Ulysses. It has been tested in some clinical areas prior to end of December 2019 and plan to roll out across all areas to establish base line assessment prior to 31st March 2020.

Date Entered : 11/01/2020 10:56
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**
4 Major	2 Unlikely	8

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Governance | **Service / Department:** Executive Office | **Position at:** 30/04/2020 18:41:41

Risk Number: 2297 **Version:** 3 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

Executive Lead: Andrew Loughney **Operational Lead:** Jennifer Huyton

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 06/05/2020

Risk Description:

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

Cause: Lack of on site 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 co-located paediatric surgical support.

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

Last Review Narrative: **Date:** 06/04/2020 **Reviewed By:** Jennifer Huyton

Risk reviewed by Head of Strategy and Transformation.

Target completion dates for a number of actions amended in light of Trust response to COVID19. Progress against all actions noted. One action completed (develop counterfactual argument) and new action added; external review of counterfactual case.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Continuing dialogue with regulators Active management with all commissioners Putting People First Strategy Leadership and Management development programme Programme for a partnership in relation to Neonates with AHCH has been established. £15m capital investment in neonatal estate to address infection risk Transfer arrangements well established for neonates and adults Formal partnership and board established with Liverpool Universities Hospitals with respect to: -Diagnostics -Medical and surgical expertise -Intensive care facilities -Theatre access at Liverpool Universities Hospitals for women with Gynae cancers Blood product provision by motorised vehicle from near by facility. Investments in additional staffing inc. towards 24/7 cover Enhanced resuscitation training provision Future Generations project group established with the Trust	Clinical case for change is dependent on decision making external to the Trust (NHSE) Lack of system support outside of Cheshire and Mersey to secure the capital case H&CP submissions for capital bids not successful despite system agreement of clinical case Financial and workforce constraints for delivery of additional facilities on site. - No blood bank on site -No 24/7 cover on site - No CT Neonatal unit at Alder Hey Children's Hospital funding agreed re: capital. Alder Hey Children's Hospital estate not yet established Onsite and partnership mitigations cannot fully address the clinical risk - this can only be achieved through co-location Emerging clinical standard leading to potential lose of services and increase in difficulty in relation to recruitment of consultants	Not Effective	Corporate Objectives 2019-20 Board performance reports DIPC Reports Staff Staffing levels reports to board Incident and Serious Incident reports to Safety Senate Quality Committee, Divisions and Trust Board. Mortality and Morbidity reviews in all areas Performance monitoring of patient experience and clinical outcomes Transfers out monitored at HDU Group Data reviewed regularly and reported through HDU and Sepsis Group.	Approval of NNU Business case CQC inspection (2018) - Good Meetings with CCG via Clinical Quality and Performance Group (CQPG) Negative - North East clinical senate report - Neonatal ODM - Maternity SCN Dashboard Counterfactual clinical case (2020) Output from Clinical Summit report (2019) Divisional Performance Reports Quality Data Serious Incident Investigation Reports	Improved data reporting required with respect to: -acuity of patients on HDU -number of women with highest level of medical conditions - in maternal and Termination of Pregnancy Services -Where services data is collated and acted upon	Positive

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	29/10/2021	Andrew Loughney	Target date changed to come into line with business case action plan - risk number 1986 Date Entered : 04/03/2020 07:28 Entered By : Christopher Lube ---------- 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	29/04/2022	Jennifer Huyton	Target date changed to come into line with business case plan - risk 1986 Date Entered : 04/03/2020 07:29 Entered By : Christopher Lube ---------- To be monitored monthly Date Entered : 09/08/2019 13:41 Entered By : Christopher Lube	Ongoing	/ /

4	Divisional plans to be developed to support long term clinical sustainability via operational plan	01/04/2019	30/04/2020	Jennifer Huyton	Target date amended due to response to COVID19. Draft divisional plans presented to Senior Management Team in Feb/March 2020. Completion of final versions currently paused due to operational response to COVID19. Target completion date will remain under regular review. Date Entered : 06/04/2020 12:16 Entered By : Jennifer Huyton ---------- Operational plans under development but not due until March 20. Target date amended to March 20. Date Entered : 10/01/2020 14:18 Entered By : Jenny Hannon ---------- Work ongoing in Divisions Date Entered : 09/08/2019 13:46 Entered By : Christopher Lube	Ongoing	/ /
5	Outcomes from the clinical summit to be actioned.	27/09/2019	30/06/2020	Jennifer Huyton	Target date amended due to response to COVID19. Good progress had been made towards implementation of actions. Partnership Board established with LUHFT. Work now paused due to COVID19 but will remain under regular review. Date Entered : 06/04/2020 12:09 Entered By : Jennifer Huyton ---------- CT scanner and Blood Bank provision has been added to the draft operational plan, which is awaiting approval. Date Entered : 04/03/2020 07:27 Entered By : Christopher Lube ---------- Target date amended following development of MoU with LUH. Detailed plan is in place (to be attached) actions are in progress Date Entered : 10/01/2020 14:18 Entered By : Jenny Hannon ---------- Acting Medical Director working with Strategic Finance Manager on reviewing summit outcomes. Date Entered : 27/09/2019 08:43 Entered By : Christopher Lube	Ongoing	/ /
7	Management of Future Generations Strategy through Project Management Office	16/11/2019	30/06/2020	Andrew Loughney	Reviewed 26 March 2020 by J Huyton: Project Manager recruitment completed in March 2020; post	Ongoing	/ /

					successfully appointed. Start date anticipated June 2020. Majority of FG programme paused during response to COVID19; work remains under regular review by PMO team. Date Entered : 06/04/2020 12:06 Entered By : Jennifer Huyton			
8	Development of counter factual arguement	16/11/2019	31/03/2020	Jennifer Huyton	Counterfactual case developed and tested with clinical teams. paper submitted to Quality Committee in March 2020 for review. Date Entered : 06/04/2020 11:50 Entered By : Jennifer Huyton		Completed	06/04/2020
9	Agree funding for mitigations on site (Blood Bank, MRI, Diagnositics, CT and Staffing) for inclusion in 20/21 operational plan	31/03/2020	30/06/2020	Jennifer Huyton	Reviewed 26 March 2020 by J Huyton: Application for emergency capital funding submitted to NHSI/E in Feb 2020 with decision originally expected early April. Revised guidance now expected from NHSE/I regarding emergency capital in light of response to COVID19. Guidance will be reviewed once released and target completion dates amended accordingly. Date Entered : 06/04/2020 12:00 Entered By : Jennifer Huyton		Ongoing	/ /
10	Lobby systems and MP's for active support	16/11/2019	30/06/2020	Kathryn Thomson	Reviewed 26 March 2020 by JHuyton: This work is ongoing but paused at present due to response to COVID19. Action completion dates will remain under regular review as situation develops. Date Entered : 06/04/2020 12:03 Entered By : Jennifer Huyton		Ongoing	/ /
11	External review/testing of counterfactual case	01/04/2020	30/09/2020	Jennifer Huyton	Counterfactual case developed and ready for external review, challenge and testing. Process likely to be delayed due to response to COVID19. Target completion dates will be reviewed regularly as response develops. Date Entered : 06/04/2020 11:55 Entered By : Jennifer Huyton			/ /

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:** 30/04/2020 18:41:41

Risk Number: 2335 **Version:** 1 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

Executive Lead: Jenny Hannon **Operational Lead:** Matt Connor

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Finance, Performance & **Review Due:** 14/05/2020

Risk Description:

Condition: Major and sustained failure of essential IT systems due to a cyber attack

Cause: ineffective cyber controls and technology, inadequate investment in systems and infrastructure, failure in skills or capacity of staff or service providers, poor end user culture regarding cyber security and IT systems use, inadequate contract management.

Consequence: Reduced quality or safety of services, financial penalties, reduced patient experience, loss of reputation, loss of market share/ commissioner contracts.

Last Review Narrative: **Date:** 14/04/2020 **Reviewed By:** Matt Connor

Risk reviewed, no material change to risk.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	1. Microsoft Windows security and critical patches applied to all Trust servers on all servers\laptops and desktop devices on a monthly basis. 2. Network switches and firewalls have firmware updates as and when required installed. Wifi network firmware patches applied for Controllers and Access points. 3. Mobile end devices patched as and when released by the vendor. 4. Externally managed network service provider to ensure network is a securely managed with underpinning contract. 5. Robust carecert process to enact advice from NHS Digital regarding imminent threats. 6. Network perimeter controls (Firewall) to protect against unauthorised external intrusion. 7. Robust Information Governance training on information security and cyber security good practice. 8. Regular staff educational communications on types of cyber threats and advice on secure working of Trust IT systems.	Lack of Cyber Security strategy	Effective	Cyber Essentials Plus Standards/ KPIs IMT Risk Management Meeting Digital Hospital Sub Committee Finance, Performance & Business Development	MIAA Cyber Controls Review Cyber Essentials Plus Accreditation Cyber Penetration Test NHS Care Cert Compliance	None known at this time	Positive
Detect	1. Malware protection identifies and removes known cyber threats and viruses within the Trusts network and at the network boundaries. 2. Cyber Security Monioring System identifies suspicious network and potential cyber threat behaviour. 3. National CareCert alerts inform of known and imminent cyber threats and vulnerabilities.	1. Lack of Network Access Controls within the physical network.	Effective	Cyber Essentials Plus Standards/ KPIs IMT Risk Management Meeting Digital Hospital Sub Committee Finance, Performance & Business Development	MIAA Cyber Controls Review Cyber Essentials Plus Accreditation Cyber Penetration Test NHS Care Cert Compliance	None Known at this tiime	Positive
Contingency	1. Departmental Business Continuity Plans being invoked. 2. Enactment of the IMT Dept. Disaster Recovery (DR) Plan 3. Seek C&M system wide support in recovery.	None known at this time	Not Yet Tested	~~EPRR~~	MIAA Audit on BCP and DR C&M Cyber Security workstream C&M Digital Leadership forum	None known at this time	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Implementation of the MIAA Cyber Security audit action	12/03/2020	31/08/2020	Philip Moss			/ /
2	Implementation of new network will introduce enhanced security capabilities.	13/03/2020	30/07/2020	Philip Moss			/ /
3	Implement a Cyber Security strategy	01/04/2020	30/09/2020	Matt Connor			/ /

Initial Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	4 Likely	20

Current Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	3 Possible	15

Target Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	2 Unlikely	10

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** IM & T | **Service / Department:** Executive Office | **Position at:** 30/04/2020 18:41:41

Risk Number: 2337 **Version:** 1 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

Executive Lead: Jenny Hannon **Operational Lead:** Matt Connor

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 30/05/2020

Risk Description:

Condition:The Trusts current clinical records system (paper and Electronic) are sub-optimal.

Cause: Failure to upgrade present Electronic Patient Records system in recent years and failure of 3 Trust electronic Patient Records to deliver on time.

Consequence: There is potential impact on patient safety, quality, experience and negative effect on staff, Staff are unable to work effectively and safely.Reporting requirements will be impacted if systems fail. There is a financial cost of replacement and penalties to the Trust, of withdrawal from three way electronic Patient record

Last Review Narrative: **Date:** 30/04/2020 **Reviewed By:** Christopher Lube

Work continues as planned on identified actions

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Maintenance of present system Development of individual / service solutions e.g. PENs (Gynaecology) and Staff training Development and deployment of ADT Whiteboard system to reduce risk of multiple systems. Incident reporting Oversight form Digital Hospital Committee, reporting into Finance, Performance and Business Development Committee (FPBD). Quarterly risk assessments reported to FPBD Tactical solutions including planned purchase of K2 Athena system Single Sign on Financial provisions made for exit penalties Exchange/LHCRE enables for patent information sharing Legal Advice from Hill Dickinson regarding previous system supplier Robust exit action plan to mitigate residual financial exposure and liability	Leadership group to be set up to manage clinical and financial implications of new system New product to be procured No plan for development and implementation phase Staff fatigue and loss of confidence. Not all Trust using LHCRE for patient information exchange	Effective	Quarterly risk assessments completed Quality Committee oversight and scrutiny FPBD Committee overview and scrutiny Digital Hospital Committee oversight	Independent lessons learnt review	Lack of Information Management &Technology Strategy Reactive rather than proactive identification and approach to problems caused by current sub optimal Electronic Patient Record, including patient risk and staff experience. Lack of revised business case	Positive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Terms of Reference for leadership group to be formalised	24/03/2020	30/04/2020	Andrew Loughney			/ /
2	Business case for revised system	24/03/2020	30/04/2020	Matt Connor			/ /
3	Develop staff communication plan for new system	24/03/2020	30/04/2020	Andrew Duggan			/ /
4	Develop plan for system development and implementation	24/03/2020	30/04/2020	Matt Connor			/ /
5	Procurement of new system following evaluation	24/03/2020	31/07/2020	Matt Connor			/ /
6	Ongoing review of systems and mitigations quarterly (report to FPBD & QC)	24/03/2020	31/12/2020	Matt Connor			/ /
7	Development of an Information Management And Technology Strategy	24/03/2020	31/05/2020	Matt Connor			/ /

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

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** EPRR | **Service / Department:** Executive Office | **Position at:** 30/04/2020 18:41:41

Risk Number: 2340 **Version:** 1 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

Executive Lead: Kathryn Thomson **Operational Lead:** Gary Price

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Finance, Performance & **Review Due:** 14/05/2020

Risk Description:

Condition: Failure to maintain current levels of service, manage increased demands and provide support to the wider system. Failure to recover to pre-Covid-19 service levels following the pandemic.

Cause: Increased demand on services and the requirement to provide support to the wider system for ITU and acute beds capacity during the Covid-19 pandemic. Cancellation of a number of elective services to release beds to the wider system. There are a high number of clinical staff not able to work due to Covid-19 health restrictions. Requirement to follow national guidance.

Consequence: Lack of service provision to Liverpool Womens Hospital patient groups, reduced services in some areas, life altering impact on some patients, reduced patient experience, impact on patient safety and potential loss of reputation and inability to recover service provision in the future.

Last Review Narrative: **Date:** 30/04/2020 **Reviewed By:** Christopher Lube

Command and control continues in place as required, CAG providing support and advice to senior management. All alerts or required actions are being reviewed and discussed at morning command meeting and Oversight meeting. Links into local and regional systems maintained. Mutual aid provided and received as required. Updates on PPE provided daily and closely monitored.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	RESPONSE Command and Control arrangements in place led by Executive Directors Regional Director of Nursing and Medical Directors groups meeting to discuss issues and develop assistance. Cheshire and Mersey Coordinated response including Chief executive Officer briefings and Hospital Cell approach Twice weekly operations and oversight meetings chaired by Chief Executive Officer (internal) Daily incident meetings to support and respond to challenges Planning and monitoring of activity on a daily basis by Divisional Managers Partnership working with Liverpool University Hospitals, Alder Hey Hospital and wider Cheshire and Mersey network for coordinated provision of support Clear and on-going communication with the Clinical commissioning Group and Specialist Commissioners Working as part of the regional Local Resilience Forum Business Continuity Plans in place Pandemic plan in place and being followed Daily safety huddle Daily clinical Advisory Group (CAG) meetings. STAFFING Staff working from home wherever possible, move to virtual meetings and enhanced IT provision. Clear staff absence process and monitoring with increased flexibility. Enhanced well being support for staff Strict supply and demand process for Personal Protective Equipment in place. Fit testing process in place fro FFP3 masks Clear criteria as to elements of activity and types of patients the Trust can assist with. Close working with Director of Infection Control and Infection Control team. Daily staff communications Daily Floor walkers established to support staff PATIENTS Clear communication to patients via direct communications and social media. Review of national guidance re:activity delivery via Clinical Advisory Group PALS service continuing Visiting Policy amended to reduce risk of spread Family liaison service established to supplement PALS service.	External pressures on neighbouring Trust beds and services, impacting on ability of the LWH Trust to access critical care and other services. Ability to control PPE deliveries from centre Lack of sufficient testing and screening for staff and patients.	Effective	Twice weekly Operations and Oversight meetings are effective Board Committee meetings continuing (although adjustments made). Maintenance of assurance reporting (performance metrics etc.) - identification of key performance measures. Reduced footfall though the Trust - activity and visitors (comms) Corporate BAU largely maintained despite remote working.	daily Regional command meetings Oversight by NHSE/I Oversight by Commissioners Audit of financial accounts Nnational Health Servicee Resolusion.	Ecternal audit activity suspended for Qulaity Account Internal normal business audits ahve stopped due to workload Reductin in some performance measurement due to pressures Lack of covid-19 testing for staff.	Positive
Contingency	BUSINESS AS USUAL and RECOVERY Commitment to deliver Business as Usual wherever possible		Not Yet Tested				Inconclusive

Executive lead assigned to manage Business as Usual
Corporate controls remain in pace
On-going regulatory compliance
Recovery plans in development to include areas of good practise which should be maintained

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Ongoing dialogue with partners and consideration of mitigating arrangements to be introduced on site via Clinical Advisory Group	01/04/2020	30/04/2020	Andrew Loughney			/ /
2	Ambulance to be procured to transport Neonates	01/04/2020	30/04/2020	Andrew Loughney			/ /
3	Ongoing review of directives across national, regional and local forums	01/04/2020	30/06/2020	Andrew Loughney			/ /
4	Close working with Cheshire and Mersey procurement via Covid Supply Response (CSR)	01/04/2020	31/05/2020	Amy Noble			/ /
5	Work with partners such as Liverpool University to develop alternative means of supply	01/04/2020	31/05/2020	Andrew Loughney			/ /
6	Consider alternative routes for staff and patient testing via the Clinical Advisory Group and in discussion with local partners and regional leadership	01/04/2020	30/04/2020	Andrew Loughney			/ /
7	Monitoring of staff testing availability- to date 35 staff have been tested. The process for testing is progressing smoothly, with daily reports sent from HR to the testing team for them to book appointments. Results are being returned within 24 hours.	01/04/2020	30/04/2020	Rachel London	Staff Testing continues to progress well with an average of 5-10 staff per day being tested. Children of staff members are now being tested at a Liverpool City Centre testing facility. Currently testing continues in line with SOP - testing takes place on day 1-5 of symptomatic member of staff or household contact only. Some specialist Trusts approached to be part of an asymptomatic testing pilot but LWH was not approached. Date Entered : 29/04/2020 13:22 Entered By : Rachel London	Ongoing	/ /

Initial Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	4 Likely	20

Current Assessment		
Severity	Likelihood	Risk Score
4 Major	4 Likely	16

Target Assessment		
Severity	Likelihood	Risk Score
2 Minor	4 Likely	8

Agenda Item	2020/

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Corporate Objectives 2019/20 Annual Review and Corporate Objectives 2020/21**
DATE OF MEETING:	Thursday, 07 May 2020
ACTION REQUIRED	**For Approval**
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	Mark Grimshaw, Trust Secretary
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust……* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒

	5. *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……..* ☒ ***6.*** *Ineffective understanding and learning following significant events……..* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) …….* ☒ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☒ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services..* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes,* ☒ *promotes a good quality of life and is based on the best available evidence.* ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity* ☒ *and respect.* ***RESPONSIVE –*** *the services meet people's needs.* ☒ ***WELL-LED -*** *the leadership, management and governance of the* ☒ *organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ***ALL DOMAINS*** ☒
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☒ **3.** NHS Compliance ☒ **4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: **Click here to enter text.**

FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: *(eg: The Board/Committee is asked to:-….)*	***The Board is asked to note and agree: the performance for the year against the Corporate Objectives 2019/20; and the Corporate Objectives 2020/21.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	*Choose an item.* SEE BELOW *Click here to enter text.*
	Date of meeting	*Click here to enter a date.*

Report

The Board of Directors formally approved the Corporate Objectives for 2019/20 at a meeting held on 2 May 2019 and agreed the alignment of objectives to Board Committees for periodic review.

These reviews were undertaken by the relevant Board Committees in November 2019, with a six-month outturn position reported to the Board in December 2019.

Both the Quality Committee and the Finance, Performance and Business Development Committees considered the year-end outturn position at their March 2020 meetings. Also considered were the draft 2020/21 Corporate Objectives aligned to their area of responsibility in March 2020. It was requested that further consideration be given to the objectives taking into account the potential impact of the COVID-19 pandemic. The Executive Team took the opportunity to review the 2020/21 corporate objectives in the round. Whilst some small changes were made, a general principle was agreed that it was important to maintain 'business as usual' as much as was practicable.

The Putting People First Committee reviewed the 2019/20 outturn position and the draft 2020/21 corporate objectives at the April 2020 meeting.

The cycle of periodic review usually involves the Committees and the Board reviewing progress on the Corporate Objectives on a six-monthly basis. In light of the Covid-19 pandemic, and to ensure that the objectives remain feasible and deliverable, it is suggested that the 2020/21 objectives be reviewed in three months and then again at six months.

<u>Recommendation</u>

The Board is asked to note and agree:

- the performance for the year against the Corporate Objectives 2019/20;
- the Corporate Objectives 2020/21; and
- that a review of the 2020/21 Corporate Objectives be undertaken in three months and then again at six months.

STRATEGIC AIMS AND CORPORATE OBJECTIVES 2019/20

Year-end Outturn Position

The Vision Aims and Values have been developed over a long period of time with input from the Board, Staff, Governors and Stakeholders.

Our vision: To be the recognised leader in healthcare for women, babies and their families

Our strategic aims –
WE SEE:

W To develop a well led, capable, motivated and entrepreneurial **W**orkforce;
E To be ambitious and **E**fficient and make best use of available resources;

S To deliver **S**afe services;
E To participate in high quality research in order to deliver the most **E**ffective outcomes;
E To deliver the best possible **E**xperience for patients and staff.

Our values –
We CARE and we LEARN:

Caring – we show we care about people;
Ambition – we want the best for people
Respect – we value the differences and talents of people;
Engaging – we involve people in how we do things;
LEARN – we learn from people past, present and future.

Corporate Objective To be ambitious and Efficient and make best use of available resources	Executive Lead	Relevant Strategy	Board Committee	Year-end Outturn
Deliver the financial plan for 2019/20	DoF	Operational Plan 19/20	FPBD	The Trust delivered the financial plan for 2019/20, including the delivery of CIP. There are however concerns in relation to the underlying position and levels of activity moving into 2020/21.
Deliver the operational plan for 2019/20	DoO	Operational Plan 19/20	FPBD	The Trust performed well against many national quality and performance standards. In respect of the targets the Trust did not achieve, significant work was undertaken in 2019/20 to improve these. In 2019/20 The Trust has worked closely with NHS Improvement and Liverpool CCG in implementing new electronic systems and processes that included robust monitoring and reporting strategies embedded into business as usual. Priority for the trust has been on assuring the longest waiting patients are cared for appropriately. The Trust has eliminated long waiters in 2019/20 and has increased clinical capacity to improve this further. Reviews of demand and capacity for services are now part of routine planning. The Trust delivers well against the urgent cancer referral target, however due to clinical capacity has faced challenges in delivering the Cancer diagnostic and 62-day target. Work with the Cheshire and Mersey Cancer Alliance has progressed well to enable a pan-regional approach to be taken to address the challenge of improving the Cancer 62-day targets. This work has identified areas for further collaboration and has ensured a renewed focus on potential streamlined models of care, including areas such as access to diagnostics.

Demonstrate the effective use of resources in providing high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review of Operational productivity and current National initiatives (Model Hospital/GIRFT)	DoF	Operational Plan 19/20	FPBD	The Trust has an RCI (reference cost index) score of 101, which is good in view of the standalone nature, and size of the Trust. Model hospital and GIRFT data is used, although limited, to inform planning. Robust processes were in place to identify and review the effectiveness and impacts of Cost Improvement initiatives which were developed with the services and approved by the Director of Nursing and Midwifery and Medical Director. The Trust has worked with the HCP to try to develop a more joined up approach to the effective use of resources and cost improvements. The Trust continues to participate in collaboration at scale work streams across Cheshire and Merseyside. Efficiencies and the effective use of resources however is impacted on an ongoing basis by being on a standalone site, and the requirement for clinical workarounds and this is likely to deteriorate with further investment on Crown Street.

Corporate Objective To deliver **S**afe services	Executive Lead	Relevant Strategy	Board Committee	Year-end Outturn
Maintain regulatory confidence & compliance	CEO	All	All	• The Trust continually keeps NHSI/E and CQC up to date with developments within the Trust and confidence in management and compliance is high. • Attendance and reporting at System Assurance meetings led by NHSI/E. • Achieved overall 'Good' rating following CQC inspection in April 2019 • Monthly and annual submissions to NHSI/E completed within timeframes set • Annual Report and Accounts 2018/19 submitted to Parliament within required timeframes.

Successfully delivering Year 2 of the Neonatal new build	MD/DoO/ DoF	Future Generations	FPBD	The first phase of the build is now complete, and the facility is now in clinical use. The time for completion remains within two weeks of plan and within budget.
Working in partnership with providers and commissioners to ensure quality safe services are delivered to the population of the region. This will include working closely with the following:- • Cheshire and Merseyside Partnership (STP) to develop and influence regional strategy • Liverpool CCG in supporting the Place plans • Alder Hey to implement the Neonatal Single Service on two sites	DoO	Operational Plan	FPBD	The Trust plays an active role in the Cheshire and Mersey Health and Care Partnership (HCP) which was previously known as the STP. The Women and Children's workstream for this programme is being refreshed and the Trust is promoting the sustainability of LWH in its current form as one of the key regional challenges to the sustainability of acute services. The Trust was an active participant in the development of the Liverpool Place Plan and features in both that and the Health and Care Partnership Plan. The Trust has developed a Liverpool Neonatal Partnership with Alder Hey Children's Hospital to provide best care and support for neonatal surgical babies. The partnership has recruited a leadership team and is developing and enhancing staffing to support delivery and development of this service through into 20/21 and beyond. The Trust has also signed an MOU with LUFT to enable more robust partnership working going forward.
Electronic Patient Records project delivery and implementation with required timeframe • Dependant on outcome discussions	DoF/MD/ DoO	EPR Project Plan	FPBD/ Quality Committee	The plan to install the third-party product for a EPR across LWH and LUFHT hospital sites has been stopped. At LWH, the purchase of a maternity EPR (K2) has been completed and a project group has been put together with the aim introducing it into the clinical arena by the year end 2020. The Trust's newly appointed CIO has been given the task of procurement and implementation of a new Trust-wide EPR through robust clinical engagement. Regular risk assessments are carried out in relation to the current systems. Positive progress has been supported via the GDE program.
Develop IM&T as a strategic enabler ensuring that clinical systems are fit for purpose, forward focussed and embrace the wider strategic view of the health economy	DoF	IT Strategy	FPBD	The GDE Fast Follower program and milestones, linked to the Health and Care Partnership Digit@ll strategy have formed the basis of the 2019/20 strategy. The GDE program

				milestones have been achieved and have underpinned positive clinical developments throughout the year, although delays to EPR have meant that the position is sub-optimal. The future strategy will be developed during 2020/21 by the CIO via strong clinical engagement and listening events and workshops.
Corporate Objective To deliver **S**afe services	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Year-end Outturn**
Delivery of in-year Quality Strategy objectives	MD/ DoN&M	Quality Strategy	Quality	The third year of the 2017/2020 Quality Strategy is nearing completion and the nine stated strategy objectives have been met. A new five-year quality strategy for 2020-2025 has been created in draft form. Following feedback from the Quality Committee and taking into consideration the findings from the CQC inspection, the updated Quality Strategy will have a focus on quality improvement.
Deliver the objectives defined in the Trust LocSSIP Group's Terms of Reference	MD	Quality Strategy	Quality	Phase 1 of the LocSSIPs implementation plan (operating theatre focus) has completed with data now being demonstrated on PowerBI. There is good evidence of engagement from clinical staff. Phase 2 (focus on non-theatre environments) is now in development. The objectives of the ToR are therefore being met.

Corporate Objective To participate in high quality research in order to deliver the most **E**ffective outcomes	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Year-end Outturn**
Develop closer working relationships with University of Liverpool with respect to research and innovation	MD	R&D	Quality	The UoL Executive PVC has joined the LWH BoD as a Non-Executive Director, strengthening the ties between the two organisations. The Trust worked with the UoL in a successful bid to secure funding from the Wellcome Trust for a cohort study called C-Gull, which focusses on health inequalities. This was a major academic success with clear linkage to local healthcare needs, in keeping with the Trust's strategy.

Successful implementation of the Trust's Research and Development Strategy to enhance the Research and Innovation capabilities of the Trust	MD	R&D	Quality	In keeping with the Trust's strategic principles, LWH has increased its commitment to Liverpool Health Partners by supporting the newly established city-wide Joint Research Service and by leading the 'Starting Well' workstream together with AHUH. There continues to be an investment in consultant PAs to support research.
Corporate Objective To deliver the best possible **E**xperience for patients and staff	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Year-end Outturn**
Providing a patient led experience, continuously seeking feedback to further enhance our service provision.	DoN&M	Patient Experience Strategy	Quality	The Trust continues to monitor the Patient Experience Strategy through the Experience Senate. A texting facility has been rolled out to Gynaecology, Maternity and Genetics, this has increased patient feedback as part of Friends and Family Test. From 1 April 2020, revised FFT guidance will replace all previous guidance, this will also be when the texting facility will be rolled out to other areas. There is a new standard question for all settings: "Overall, how was your experience of our service?". There will still be cards available in the areas for those who do not have access to text or online services. This is monitored via the Experience Senate and also by the CCG. Regular monitoring and review of trends and themes from patient complaints and PALs contacts are provided to the Experience Senate and to the Quality committee to ensure that we are able to put actions in place in response to trends or themes. Further work is ongoing in relation to the collation of themes and trends from PALs+ meetings to ensure all areas receive appropriate feedback to plan actions. Regular monitoring and review of trends and themes from patient complaints and PALs contacts are provided to the Quality Committee quarterly to ensure that we are able to put actions in place in response to trends or themes.

Corporate Objective To develop a Well Led, capable, motivated and entrepreneurial Workforce	Executive Lead	Relevant Strategy	Board Committee	Year-end Outturn
Improving the Health & Wellbeing of the workforce by moving to upper quartile performance for % sickness absence and stress related absence incrementally between 2019-2021 as measured by the Annual Staff Survey	DoW&M	People Strategy	Putting People First	• HWB priority focus for 19/20 was mental wellbeing. The PPF Strategy provides a five-year target to achieve 10% of the workforce training as Mental Health First Aiders. The Trust has trained 70 MHFAs to date across a range of departments/disciplines • HWB objective became mandatory for all people managers from January 2020 – to support strategic aim on HWB being viewed as a positive leadership behaviour and ensure engagement of people managers with the Trust wide options for supporting and improving HWB. • Quarterly health education campaigns introduced from October 2019, with the support of Occupational Health. Q1 = flu jabs; Q2 from January to March 2020 will be focussed on proactive targeted staff physio sessions where sickness related to musculoskeletal issues is high. • The rate of sickness absence this year so far has consistently tracked above target – localised plans are in place to focus on this. • Freedom to Speak Up Guardian service actively promoted and known to staff.
Improving the organisation's climate and increasing the overall staff engagement score (as measured by Annual Staff Survey & the Staff Friends & Family Test) to upper quartile for acute specialist Trusts incrementally between 2019-2021	DoW&M	People Strategy	Putting People First	• Staff engagement – continued improving trend over last four years as evidenced by 2019 Staff Survey including 7% improvement in recommendation as a place to work & 3.4% improvement in recommendation as a place for treatment • Fair and Just Culture project has continued, with a full programme of book clubs for managers, and with a pilot of the training programme. Programme slowed slightly in Q3 &4 due to sickness of Project Lead but recovery plan in place

				• The pilot of the electronic quarterly survey "Listening to Our People" will draw to close at the end of the current annual contract. Response levels have been low and new model to be in place for 2020/21 • Summer of Listening events took place between June and September 2019. Outputs collated to inform Divisional People Plans.
Expanding the Trust's reach into its communities through extending its work experience, work training, guaranteed interview and apprenticeship schemes	DoW&M	People Strategy	Putting People First	• ***Work Experience*** **-** Placements for school students remain in high demand. All areas booked until March 2020. Next year is filling up fast with schools block booking unpopular weeks so that an even spread of students throughout the year is achievable. • ***Pre-employment*** **-** The third cohort of Pre-Employment participants has recently been completed. Once again the Trust has been able to offer Bank worker contracts to the majority of participants. • ***Acorns*** **-** This is a programme that replaces the familiar nursing cadets. It is a Health and Social Care Level 3 Extended Diploma course that allows students to have a placement in a healthcare setting and complete the Care Certificate and provides necessary qualifications to go onto higher study (eg nursing, paramedics, midwifery). The Trust is running this programme in partnership with Southport College. The first cohort of Acorns commences in January 2020 • **Greenbank College** - The Trust continues with our 2 learning disability students on a year long placement from Greenbank College. **Schools Activities –** The Trust continues to support local schools and colleges by participating in events in the community around healthcare careers

Shaping workforce to meet operational needs through effective workforce planning and partnerships	DoW&M	People Strategy	Putting People First	• The Trust continues with the approach to workforce planning with finance, HR and operational colleagues working closely together to define and plan future workforce needs. • The Trust has participated Health Education England's national workforce planning data collection processes. • PPF continues deep dives into workforce risks & mitigation • Funding secured from Leadership Academy for Shadow Board project to develop Board directors for the future. The programme starts in January 20 and runs for 6 months. • Pension alternative award scheme now in place • Neonatal Partnership established with a shared workforce model in place Shared appointments in hard to fill roles with partner organisations
Corporate Objective To deliver Safe services	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Year-end Outturn**
Maintain Safe Staffing levels	DoN&M	Quality & People Strategies	Putting People First	• Continue to provide monthly safer staffing papers to the Board, triangulating red flags against staffing levels and monitoring areas of high vacancies as mirrored with the National Picture of workforce across Nursing and Midwifery. • Commenced advanced midwifery practitioner pilot • Surgical Care Practitioner recruited and commenced training • Continue to identify shared ways of working to minimise clinical risk and improve recruitment to hard to fill roles • Piloting Maternity Advance Practitioner roles
Implement Fair & Just Culture	DWM	People Strategy	Putting People First	• Fair & Just Culture workplan rolled out • Fair & Just Culture methodology adopted in practice in areas/incidents

				• 10% increase in staff indicating they feel they would be treated fairly if involved in an incident, claim or complaint (2019 Staff Survey)

Corporate Objective Delivery of the Future Generations Strategy	Executive Lead	Relevant Strategy	Board Committee	Year-end Outturn
Support Commissioners and Regulators to agree strategic direction for Trust services, commencing with public consultation and Commissioner Decision Making Business Case.	CEO	Future Generations	Board specific	• Extensive engagement with Commissioners and Regulators throughout the year to date to ensure that the Trust's strategy is reflected in both local and regional plans (HCP, One Liverpool). • Direct engagement with national and regional senior leaders in relation to the Trust's clinical case and capital requirements • Public Consultation Readiness Assessment prepared and circulated to commissioners with action plan • Participation with commissioners and regulators to review and address issues arising from being on an isolated site (SIQSG) • Future Generations external work streams and governance re-established to progress case (paused due to COVID)
Work jointly with other providers and regulators to consider options for future collaborations and organisational form.	DoF	Future Generations	Board specific	• Partnership Board with Liverpool University Hospitals NHS Foundation Trust underpinned by a Memorandum of Understanding. • Partnership agreement with Alder Hey to support neonatal surgery arrangements • Engagement in the Cheshire and Merseyside Health and Care partnership work streams inc Women's and Children's and Acute Sustainability.
Retain Public and Staff Confidence through an effective Communications and Engagement Strategy	DoW&M	Future Generations	Board specific	Actions taken in accordance with the delivery plan for 2019/20 FG Communications Strategy reviewed and refreshed with Board in September 2019.

STRATEGIC AIMS AND CORPORATE OBJECTIVES 2020/21

Proposed Objectives

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

To be ambitious and Efficient and make best use of available resources			
Corporate Objective – Proposed update	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Deliver the financial plan for 2020/21, achieving quarterly targets and optimising the opportunities for financial recovery funding through system working.	DoF	Operational Plan 2020/21	FPBD

Deliver the operational plan for 2020/21, achieving quarterly targets and ensuring that appropriate actions are in place to respond to areas of underperformance.	DoO	Operational Plan 2020/21	FPBD
Demonstrate the effective use of resources in providing high quality, efficient and sustainable care, maintaining robust grip and control and ensuring that opportunities for improved working arising from the COVID-19 response are realised.	DoF	Operational Plan 2020/21	FPBD

To deliver **S**afe services			
Corporate Objective – Proposed update	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Maintain regulatory confidence & compliance	CEO	All	All
Delivery of in-year Quality Strategy objectives including the delivery of a Quality Improvement Strategy	MD	Quality Strategy	Quality
Deliver the objectives defined in the Trust LocSSIP Group's Terms of Reference	MD	Quality Strategy	Quality
Begin to embed ward accreditation across clinical areas during 2020/21	DoN&M	Quality Strategy	Quality
Development of Clinical Strategy to ensure robust recovery plans following COVID-19 and that lessons are learned.	MD	Clinical Strategy	Quality
Successfully deliver the final phase of the Neonatal new build time and to budget, as well as develop further capital investments into infrastructure which will enhance the safety of the service (blood bank, diagnostic, robotics). Develop relationships with other system providers to ensure estate utilisation and development takes into account the relevant needs of local partners.	DoO/ DoF	Future Generations	FPBD
Working in partnership with providers and commissioners to ensure quality safe services are delivered to the population of the region and to ensure operational recovery post COVID-19. This will include working closely with the following:-	DoO / MD	Operational Plan	FPBD

• Cheshire and Merseyside Health & Care Partnership (STP) to develop and influence regional strategy • Liverpool Provider Alliance in supporting the One Liverpool Plan • Alder Hey to implement the Neonatal Single Service on two sites • LUHFT to strengthen existing partnerships			
Electronic Patient Record project delivery - Identify, procure and begin to install a new record which meets the requirements of the organisation	MD	EPR Project Plan	FPBD / Quality
Develop IM&T as a strategic enabler ensuring that clinical systems are fit for purpose, forward focussed and embrace the wider strategic view of the health economy	DoF	IT Strategy	FPBD
Maintain appropriate staffing levels for the level required to maintain patient safety.	DoN&M	Quality & People Strategies	Putting People First
To implement the in-year objectives of the Fair & Just Culture Programme	DoW&M	People Strategy	Putting People First

To participate in high quality research in order to deliver the most **E**ffective outcomes			
Proposed Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Develop closer working relationships with University of Liverpool with respect to research and innovation	MD	R&D	Quality
Successful implementation of the Trust's Research and Development Strategy to enhance the Research and Innovation capabilities of the Trust	MD	R&D	Quality
Work in partnership with the University of Liverpool to prepare for implementation of the Children Growing Up in Liverpool (C-GULL) programme in 2021/22	MD	R&D	Quality

To deliver the best possible **E**xperience for patients and staff			
Proposed Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Board Committee**

Providing a patient focused experience, seeking feedback to further enhance our service provision whilst taking account of the pressures experienced by services.	DoN&M	Patient Experience Strategy	Quality

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

Agenda Item	

MEETING	**Board**
PAPER/REPORT TITLE:	**Board Terms of Reference**
DATE OF MEETING:	Thursday, 07 May 2020
ACTION REQUIRED	**Approve**
EXECUTIVE DIRECTOR:	Mark Grimshaw, Trust Secretary
AUTHOR(S):	Mark Grimshaw, 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:-….)***	***The Board is asked to:*** • ***Consider the adoption of a Board Terms of Reference in principle*** • ***If deemed appropriate, approve the adoption of the terms of reference included as appendix 1***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	N/A		
	Date of meeting			

Executive Summary

The Trust does not currently have a Terms of Reference for the Board. Whilst this is not a requirement, it is considered good practice and has been highlighted as a development point following the recently completed NHS Improvement Well-Led Framework Self-Assessment.

The Board was requested to consider the principle of adopting a Board of Terms of Reference at the April 2020 Board meeting. Approval was given to the adoption of a Board Terms of Reference. The Board was also asked provide comment on a draft document that had been adapted from a model Terms of Reference from NHS Providers' 'Compendium of Good Practice'.

The following comments were received and have been reflected in the updated draft Board Terms of Reference attached as appendix 1:

- Duties Section – substitution of the word "corporation" for "Trust"
- Duties Section – Addition of the following to the 'role of Non-Executive Directors"
    - To take an active role in providing advice, support and encouragement to Executive Directors.
- Accountability and reporting arrangements Section – removal of "by attending and observing Committees of the Board" with regards to the role of the Council of Governors.

Recommendation

The Board is asked to:

- If deemed appropriate, approve the adoption of the Terms of Reference included as appendix 1

Appendix 1:

BOARD OF DIRECTORS
TERMS OF REFERENCE

Role and Purpose:	The Terms of Reference describe the role and working of the Board of Directors (hereafter referred to as the Board) and are for the guidance of the Board, for the information of the Trust as a whole and serve as the basis of the Terms of Reference for the Board's own Committees. The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.' The Trust has a Board which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a Committee of directors or to the Chief Executive. The Board consists of Executive Directors, one of whom is the Chief Executive, and Non-Executive Directors, one of whom is the Trust Chair. The nominated deputy for the Chief Executive and Trust Chair, upon appointment to a substantive or acting up role, must be formally recorded in the minutes.
Duties:	The Board leads the trust by undertaking four key roles: • setting strategy; • supervising the work of the executive in the delivery of the strategy and through seeking assurance that systems of control are robust and reliable; • setting and leading a positive culture for the Board and the organisation; • giving account and answering to key stakeholders, particularly the Council of Governors. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust). The practice and procedure of the meetings of the Board, and of its committees, are not set out here but are described in the Board's Standing Orders.

GENERAL RESPONSIBILITIES:

The general responsibilities of the Board are:

- to maintain and improve quality of care;
- to work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, effective, accessible, and well governed services for patients, service users and carers;
- to ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity;
- to ensure relationships are maintained with the Trust's stakeholders, regulators, public, governors, staff and patients, such that the trust can discharge its wider duties;
- to exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner;
- to ensure compliance with all applicable law, regulation and statutory guidance.

In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of non-executive and executive directors.

LEADERSHIP

The Board provides active leadership to the organisation by:

- ensuring there is a clear vision and strategy for the Trust that is well known and understood by stakeholders and is being implemented within a framework of prudent and effective controls which enable risk to be assessed and managed;
- ensuring the Trust is a good employer by the development of a workforce strategy and its appropriate implementation and operation;
- implementing effective Board and Committee structures and clear lines of reporting and accountability throughout the organisation.

STRATEGY

The Board:

- sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- monitors and reviews management performance to ensure the Trust's objectives are met;

- oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- develops and maintains an annual business plan, with due regard to the views of the council of governors, and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders;
- ensures that national policies and strategies are effectively addressed and implemented within the Trust.

CULTURE, ETHICS AND INTEGRITY

The Board:

- is responsible for setting values, ensuring they are widely communicated and adhered to and that the behaviour of the Board is entirely consistent with those values;
- promotes a patient-centred culture of openness, transparency and candour;
- ensures that high standards of corporate governance and personal integrity are maintained in the conduct of foundation trust business.

GOVERNANCE

The Board:

- ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance and appropriate codes of conduct, accountability and openness applicable to NHS provider organisations;
- ensures that all licence conditions relating to the Trust's governance arrangements are complied with;
- ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
- ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective and safe services taking account of patient and carer experiences and maintaining the dignity of those cared for;
- ensures that all the required returns and disclosures are made to the regulators;
- formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation trust business;

- agrees the schedule of matters reserved for decision by the Board of Directors;
- ensures that the statutory duties of the Trust are effectively discharged;
- Acts as corporate trustee for the Trust's charitable funds.

RISK

The Board:

- ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
- ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement in the development of care plans, the review of quality of services provided and the development of new services;
- ensures there are appropriately constituted appointment and evaluation arrangements for senior positions such as consultant medical staff and those reporting to executive directors.

COMMUNICATION

The Board:

- Ensures an effective communication channel exists between the Trust, its governors, members, staff and the local community.
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback.
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publicly through Board meetings in public and also via the Trust's website.

FINANCIAL AND QUALITY SUCCESS

The Board:

- Ensures that an effective system of finance and quality is embedded within the Trust.
- Ensures that the Trust operates effectively, efficiently and economically.
- Ensures the continuing financial viability of the organisation.
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved.
- Ensures that the Trust achieves the quality targets and requirements of stakeholders within the available resources.
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

RESPONSIBILITIES OF BOARD MEMBERS

All Members of the Board:

- Have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the Chief Executive as the Accounting Officer.
- Have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

Role of the Trust Chair:

The Trust Chair is the guardian of the Board's decision-making processes and provides general leadership of the Board and the Council of Governors.

- Responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.
- Reports to the Board and is responsible for the effective operation of the Board and the Council of Governors.
- Responsible for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.

Role of the Chief Executive

- The Chief Executive reports to the Trust Chair and to the Board directly. All members of the management structure report either directly or indirectly to the Chief Executive.
- The Chief Executive is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.
- The Chief Executive is responsible for implementing the decisions of the Board and its Committees, providing information and support to the Board and Council of Governors.

Role of Executive Directors (EDs)

- Share collective responsibility with the Non-Executive Directors as part of a unified Board.
- Shape and deliver the strategy and operational performance in line with the Trust's strategic aims.

Role of Non-Executive Directors (NEDs)

- Bring a range of varied perspectives and experiences to strategy development and decision making.
- Ensure that effective management arrangements and an effective management team are in place.
- Hold the Executive Directors to account for performance of the operational responsibilities.

- Scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. NEDs should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.
- To take an active role in providing advice, support and encouragement to Executive Directors.

Role of the Senior Independent Director (SID)

- Is a Non-Executive Director appointed by the Board in consultation with the Council of Governors to undertake the role. Normally the SID will not be the Vice Trust Chair although this may be the case if the Board deems it necessary.
- Will be available to members of the Foundation Trust and to Governors if they have concerns which, contact through the usual channels of the Trust Chair, Chief Executive, Deputy Chief Executive, Director of Finance and Trust Secretary, has failed to resolve or where it would be inappropriate to use such channels.
- Has a key role in supporting the Trust Chair in leading the Board and acting as a sounding board and source of advice for the Trust Chair. The SID has a role in supporting the Trust Chair in his/her role as Trust Chair of the Council of Governors.

In addition to the duties described here, the SID has the same duties as the other Non-Executive Directors.

Role of the Trust Secretary

The Trust Board shall be supported by the Trust Secretary whose duties in this respect will include:

- agreement of the agenda, for Board and Board committee meetings, with the relevant Chair, in consultation with the Chief Executive;
- collation of reports and papers for Board and committee meetings;
- ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward;
- ensuring that board procedures are complied with;
- supporting the Chair in ensuring good information flows within and between the Board, its committees, the Council of Governors and senior management;
- advising the Board and Board committees on governance matters;
- supporting the chair on matters relating to induction, development and training for directors

Membership:	The composition of the Board shall be:
	• A Non-Executive Chair
	• Not more than seven other non-executive Directors
	• Not more than seven executive Directors including:
	  ○ The Chief Executive (who is the Accounting Officer)
	  ○ The finance director
	  ○ A registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984)
	  ○ A registered nurse or registered midwife.

Quorum:	Six Directors including not less than three executive Directors (one of whom must be the Chief Executive or another Executive Director nominated by the Chief Executive) and not less than three non-executive Directors (one of whom must be the Chair or the Vice Chair of the Board of Directors) shall form a quorum. An officer in attendance for an executive Director but without formal acting up status may not count towards the quorum. If a Director has been disqualified from participating in a discussion on any matter and/or from voting on any resolution by reason of declaration of a conflict of interest, that Director shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minute of the meeting. The meeting must then proceed to the next business.
Voting:	All questions put to the vote shall, at the discretion of the Chair, be decided by a show of hands save that no resolution of the Board of Directors shall be passed if it is opposed by all of the non-executive Directors present or by all of the executive Directors present. A paper ballot may be used if a majority of the Directors present so request. In case of an equality of votes the Chair shall have a second and casting vote. If at least one third of the Board members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot). If a Board member so requests, her vote shall be recorded by name. In no circumstances may an absent Director vote by proxy. Subject to Standing Order 59, absence is defined as being absent at the time of the vote.

	An officer who has been appointed formally by the Board to act up for an executive Director during a period of incapacity or temporarily to fill an executive Director vacancy, shall be entitled to exercise the voting rights of the executive Director. An officer attending the Board to represent an executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive Director. An officer's status when attending the meeting shall be recorded in the minutes. Where an executive Director post is shared by more than one person: • Each person shall be entitled to attend meetings of the Board • Each of those persons shall be eligible to vote in the case of agreement between them • In the case of disagreement between them no vote should be case • The presence of those persons shall count as one person.
Attendance:	The Board of Directors may agree that Directors can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting. Directors who are unable to attend a meeting shall notify the Secretary in writing in advance of the meeting in question so that their apologies may be submitted.
Frequency:	Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Secretary will publish the dates, times and locations of meetings of the Board in advance.
Accountability and reporting arrangements:	The Council of Governors is responsible for holding the Board to account, for example by attending Board meetings in public and meeting with the Trust Chair, Chief Executive and Committee Chairs on the day of Board meetings / Council of Governors' meeting. The agenda and minutes of Board meetings will be shared with the Council of Governors. The Trust Chair will be responsible for ensuring the Board of Directors adheres to its Terms of Reference and Annual Work Plan. The Board shall self-assess its performance following each board meeting. A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all directors and others as agreed with the Chair and Chief Executive from time to time.

Monitoring effectiveness:	The Board will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Board.
Reviewed by Board of Directors:	*2 April 2020 & 7 May 2020*
Approved by Board of Directors:	*TBC*
Review date:	April 2021
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